

Otolaryngology -  
 Head & Neck Surgery  
 Thomas H Hammond,  
 M.D.  
 Sam Kim, M.D.  
 Kim Shirner, PA-C

1919 Lathrop Street, Suite 104, Fairbanks Alaska 99701 | Phone: (907) 456-7768 | Fax: (907) 456-4045

## MEDICAL RECORDS RELEASE

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt. Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Zip : \_\_\_\_\_

### Records Request From:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Company/Name: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Suite Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

### Send Records To:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Company/Name: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ Suite Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

How would you like to obtain these records? Please check one:

- Mail
- Fax
- Pick-up (with photo identification)

**Please allow us 7-10 business days to copy your medical records.**

Tell us what medical records you would like sent:

- Complete Medical Records
- Lab or Pathological Records
- Audiometric Studies
- Medications
- Other: \_\_\_\_\_
- X-Ray Reports
- Operative Notes
- Chart Notes
- Allergy Records

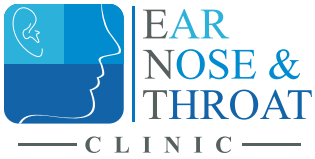
### AUTHORIZATION FOR RELEASE OF MEDICAL DATA

This authorization will expire one year from signature date below.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship: \_\_\_\_\_

### FOR OFFICE USE ONLY

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name: \_\_\_\_\_



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## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in my treatment, directly or indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as physician certifications and quality assessments

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its policy from time to time and that I may contact you to obtain a current copy.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed and that you are not required to agree to my requested restrictions, but if you do agree; then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have take action relying on this consent.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Relationship: \_\_\_\_\_

### FOR OFFICE USE ONLY

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_