Tanana Chiefs Conference Health Services Division
1717 West Cowles Street, Fairbanks, AK 99701 Telephone (907) 451-6682 Ext. 3630 Fax (844) 278-9006

MEDICAL AUTHORIZATION FOR RELEASE OF INFORMATION

Each section of the form must be completed; missing information will result in delays in processing and may be invalid

PATIENT INFORMATION:

Patient Name: _____ Birth Date: _____ Medical Record # (if known): _____

Address: _____ City/ State/ Zip: _____

I Hereby Authorize TCC Health Services Division to Disclose Information TO:

Name of Facility/ Organization/ Individual: _____

Address: _____ City/ State/ ZIP: _____

Phone Number: _____ FAX: _____

I Hereby Authorize TCC Health Services Division to Request Information FROM:

Name of Facility/ Organization/ Individual: _____

Address: _____ City/ State/ Zip: _____

Phone Number: _____ FAX: _____

□ Dates of treatment: **FROM:** ____/____/____ **TO:** ____/____/____

□ Purpose or need for information being requested:
Further Treatment: _____ Legal Proceedings:_____ School: _____ Insurance Claim: _____ Other (specify): _____

□ Type of Information to be used or disclosed:
_____ OB/GYN _____Radiology Reports _____ Radiology Images _____ Lab Reports _____ Immunization Records
_____ Consultation Notes _____ Urgent Care Records _____ Billing statements _____ History & Physical _____ EKG/Cardiology
_____ Operative Report _____ Primary Care Records _____ All Records _____ Other: _____

□ **I authorize the release of information relating to**: (Please **initial** which will be disclosed)
_____ Medical Information _____AIDS, HIV, ARC _____ Genetic Information

□ **This information may be transmitted via**: (please **initial** each approved communication method)
_____ Fax _____ Verbal _____ Electronically (**Required** to complete duty to warn) _____Hard copy

Unless revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 180 days from the date of signing.

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows TCC to release your protected health information to a person or organization that you choose. You must provide all of the contact information in order for the information to be released. • Identify the person, family member or organization to receive your information. • Provide the contact information about the person, family member or organization to receive your information. You can revoke this authorization at any time by submitting a request in writing to the TCC Privacy Officer. Revoking this authorization will not affect any action taken prior to receipt of your written request. I understand that this authorization to release information is voluntary and is not a condition of enrollment in this Health Plan, eligibility for benefits, or payment of claims. I also understand that if the person or organization I authorize to receive the information described above is not subject to federal health information privacy laws, they may further release the protected health information and it may no longer be protected by federal privacy laws. A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other legal document must be on file with TCC or submitted with this form. In Alaska, minors have a fundamental right to privacy regarding their medical care. In alignment with Alaska law and industry standards regarding teen health care and access to care TCC will allow minors between the ages of 13-18 years of age to consent to medical treatment for reproductive health and outpatient behavioral health services. One of the most significant changes will be with Athena's patient portal, Teens will have the option to establish their own patient portals, and parents and legal guardians will no longer be able to access a patient portal or medical records regarding reproductive health and outpatient behavioral health for minors between the ages of 13-18 without the teen's permission. I may inspect or copy any information used/disclosed under this authorization. I have received a copy of this authorization.

By my signature below, I certify that I have been given sufficient time to read this authorization, ask questions, and understand it:

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian (Where Required or Authorized to Consent on Behalf of the Patient) Date

_____ _____
Printed name of Parent or Legal Guardian (if applicable) Relationship to Patient

_____ _____
Signature of Witness Date

Tanana Chiefs Conference
PATIENT E-MAIL AUTHORIZATION FORM
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

I authorize TCC to communicate my protected health information through e-mail at the following:

☐ E-mail address: _____

By completing this authorization form, I understand and agree that:

- TCC will send a test email confirmation to the email address you provided. Please confirm that the email is active and accurate by responding to the test email with your name and date of birth. If TCC does not receive a reply within 5 business days, your records will automatically be mailed to the address you provided above. TCC will include "CONFIDENTAL" in the subject line of any e-mail, use a subject description that is as discrete as possible, and include a confidentiality statement in the body of the e-mail.

- The risks with using these methods of communication include, but are not limited to:
  - Messages may be sent to the wrong recipient or left at the wrong number; or
  - PHI sent to my e-mail account or accessed through an electronic device could be hacked, or otherwise inappropriately accessed if left unattended or lost.

- TCC cannot control or ensure the security of my PHI after it is sent via text, e-mail or voicemail.

- I hold TCC harmless from any liability for sending my PHI by e-mail listed above, including where my PHI is intercepted or inappropriately accessed due to hacking or failure to secure my accounts and electronic devices.

- I may revoke this authorization in writing at any time.

By my signature below, I certify that I have been given sufficient time to read this authorization, ask questions, and understand it:

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent or Legal Guardian (Where Required or Authorized to Consent on Behalf of the Patient) Date

_____ _____
Printed name of Parent or Legal Guardian (if applicable) Relationship to Patient

_____ _____
Signature of Witness Date

For TCC's Use Only: Date Received: _____ Description of Identity Verification: _____ Charges ($): _____

Name/Title of Staff Member Processing Request: _____ Date of Response/Completion: _____.

(Revised September 2019)