KODIAK AREA NATIVE ASSOCIATION

HEALTH SERVICES

Authorization for Communication of Health Information

Per HIPAA Rules and Regulations, KANA may not disclose a patient's health information to anyone without patient consent. If you would like to have anyone else involved with the coordination of your care, please complete this form. .
All information must be completed fully and accurately, or document will not be valid.

Patient Name (Last Name, First):				MI:
Telephone Number:		DOB:		
Patient Address:	City:		State:	Zip:

REQUESTOR MUST PROVIDE A LEGIBLE COPY OF LEGAL IDENTIFICATION ALONG WITH THIS FORM

I authorize Kodiak Area Native Association to verbally release my records to the following person:

Name (Last Name, First):		MI:
Telephone Number:	DOB:	
Relationship:		

Description of specific information to be disclosed, please place a ☒in all applicable box(es) below:

☐ Make or Cancel appointments for me
☐ Talk to my Doctor or other health center staff on my behalf
☐ Discuss my travel needs with KANA Patient Travel Specialists
☐ Talk to my Dentist or other dental staff on my behalf
☐ Discuss billing information with KANA billing staff
☐ Other: ____________________

Name (Last Name, First):		MI:
Telephone Number:	DOB:	
Relationship:		

Description of specific information to be disclosed, please place a ☒in all applicable box(es) below:

☐ Make or Cancel appointments for me
☐ Talk to my Doctor or other health center staff on my behalf
☐ Discuss my travel needs with KANA Patient Travel Specialists
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☐ Other: ____________________

Name (Last Name, First):		MI:
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☐ Talk to my Dentist or other dental staff on my behalf
☐ Discuss billing information with KANA billing staff
☐ Other: ____________________

I understand that this authorization is valid from the signature date. I understand that I may revoke this authorization by submitting in writing a request to Health Information Services Kodiak Area Native Association, except to the extent that action has been taken on it.

Signature: ____________________ **Date:** ____________________

Relationship to Patient: ____________________

For KANA's Use Only:
Medical Record Number (MRN): ____________ Date Copied: ____________ Staff Initial: ________

Updated 06/2023