Mountain View
MEDICAL CENTER

HIPAA Consent Form

Mountain View Medical Center has my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review Mountain View Medical Center's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that Mountain View Medical Center has the right to change their privacy practices and that I may obtain any revised notices at Mountain View Medical Center.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Mountain View Medical Center is not required to agree to the request. If Mountain View Medical Center agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Patient Name _____

Signature _____

Date _____

If signed by patient representative, print name _____

Relationship to Patient _____

Mountain View
MEDICAL CENTER

Authorization for Release of Medical Information

If fax exceeds 20 pages, please call our office before sending

Mountain View Medical Center
Pierre M. Johnson MD PC
2555 Phillips Field Rd
Fairbanks AK 99709
(907) 328-2920 FAX (907) 456-2914

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

SSN: _____ Phone Number: _____

Date of Request: _____

Purpose for this request: _____ Health Care _____ Insurance Coverage _____ Other:_____

Medical Records Requested: (Check all that apply)

_____ Imaging Reports _____ Procedure Notes _____ ALL Medical Records

_____ Lab Reports _____ Progress Notes _____ Other: _____

Dates of Service Requested: _____

I authorize Mountain View Medical Center to release information to OR to obtain information from:

_____
Name of Provide or Facility

_____
Address

_____
City/State/Zip

_____
Phone # / Fax # (include area code)

_____ _____
Signature of Patient or Representative Date

_____
Relationship to Patient