Camai
Community Health Center

HIPAA Privacy Authorization Form

I understand that Camai Community Health Center may still use and disclose protected health information as indicated in the Notice of Privacy Practices. Would you like to give someone else access to your medical records?

_____ Yes _____ No

If you answered Yes, please provide the following information on who you would like to grant access:

Full Name (please print)	Relationship to Patient	Phone	Authorized to Disclose:	
			Medical	Financial

This Authorization is being granted at the request of the patient. Unless otherwise revoked, this Authorization expires 12 months after the date of signing this form.

I understand that I have the right to revoke this Authorization at any time by sending a written notification to the address listed at the bottom of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that I have the right to refuse to sign this Authorization and that my treatment will not be conditioned on signing.

I understand that information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____
(required if patient is under 18)

Send any correspondence to:
Camai Community Health Center, P.O. Box 211, Naknek, AK 99633