Sportsman's Cove Lodge
Alaska's Friendly World-Class Sportfishing
Reservations Office
Box 8500
Ketchikan, AK 99901

Inquiries 1 800-962-7889
Business 907-247-7252
Facsimile 907-247-7255
info@alaskasbestlodge.com

Applicant's name: _____

Address: _____

_____

Phone contacts: Home: (_____)_____

Cell: (_____)_____

Patient Authorization to Health Care Provider for Disclosure (Applicant, this form allows Sportsman's Cove Lodge to speak to your health care provider about your health history)

To: _____
(Applicant, please put the name of your doctor in this blank. If left blank, this letter will be addressed to the Office Manager at the clinic or hospital you list below.)

And the: _____

_____Phone:_(_____)_____
(Applicant, please put the name of the health care facility that employs, or employed your doctor, in this blank. Also include the phone number of this facility. If you have had multiple doctors, please list the most recent doctor and/or health care facility you have visited.)

Your Patient: _____

Patient's Address:_____
(Applicant, please print your full legal name in this blank, and include your full mailing address.)

Hereby authorizes you to make the following disclosures:

1. Disclosure to be made to: Prospective employer, Sportsman's Cove Lodge or any representative on their behalf authorized in writing. In this regard, I waive any physician/patient privilege to my prospective employer named above and at the address and telephone number also provided herein. Any future disclosure may be in writing or in oral conversations at the option of Sportsman's Cove Lodge. Your full cooperation with my prospective employer is requested and appreciated.
2. Disclosure not to be made to: Any other company or person without my written approval.
3. Nature of information to be disclosed: All health care information from date of Applicant's date of birth to present as defined in Sec. 102 of the Uniform Health Care Information Act, restated herein as follows: "...any information, whether oral or recorded in any form or medium, that identifies or can readily be associated with the identity of a patient and directly related to the patient's health care. The term includes any record of disclosures of health care information."

4. Specific Release: I understand that my express consent is required to release any health care information relating to testing, diagnosis, an/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

5. Manner in which information may be disclosed: You are herby authorized and requested to permit the examination of the information described in paragraph 3. above, and the copying or reproduction of same in any manner, whether mechanical, photographic, or otherwise, as requested by my prospective employer named above.

6. Revocation of prior authorizations: I hereby revoke all medical authorizations, releases, disclosure authorization, etc., provided to you for the release of medical information for any reason or purpose whatever, and given by me prior to the date signed below.

7. Effect of photocopy of disclosure form: A copy of this disclosure form shall have the same force and effect as a signed original.

8. Period of validity of disclosure authorization form: This authorization form is effective on the date signed below and is no longer valid ninety days from said date. Thereafter, no authorization shall exist.

You are requested to disclose no information to any other person without my written authority; any prior or contrary authorization is hereby cancelled.

Date: _____ (Applicant, please fill in the date you signed this.)

Patient's ("Applicant's") Signature _____