

**WASILLA**

3066 E Meridian Park Loop, Ste. 101 **⏐** Wasilla, AK 99654

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**ANCHORAGE**

2751 DeBarr Road, Bldg. B, Ste. 310 **⏐** Anchorage, AK 99508

(907)277-9700 **[P]** **⏐** (907)258-8010 **[F]**

**Release of Information**

**Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby authorize:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE FAX

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS CITY / STATE / ZIP

**To release my medical and health information to:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME PHONE FAX

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS CITY / STATE / ZIP

**The following items MUST be initialed to be included in the use or disclosure of other health information:**

\_\_\_\_\_ HIV/AIDS related health information and/or records

\_\_\_\_\_ Mental health information and/or records

\_\_\_\_\_ Genetic testing information and/or records

\_\_\_\_\_ Drug/alcohol diagnosis, treatment and/or referral

information (Federal regulations require a

description of how much and what kind of

information is to be disclosed. Federal law prohibits

the re-disclosure of such information.)

\_\_\_\_\_ **Psychotherapy notes** (If this authorization is for the

use and/or disclosure of psychotherapy notes, then

it cannot be combined with any other

authorization.)

**By *initialing* the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:**

\_\_\_\_ Entire Medical Record \_\_\_\_ Office Chart Notes \_\_\_\_ Operative Reports \_\_\_\_ Laboratory Reports \_\_\_\_ Pathology Reports \_\_\_\_ Imaging/X-ray Reports

\_\_\_\_ ER and Urgent Care Record

\_\_\_\_ All Hospital Records

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Signature (Legal Representative’s Signature if applicable) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Legal Representative (if applicable) Relationship to Patient

*\*I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.*