Alaska's Medical Home for 45 Years

2211 East Northern Lights Blvd., Anchorage, Alaska 99508

Authorization to Use and Disclose Health Information

Patient Name: _________________________ Phone#: __________________ **Date of Birth:** _______________

Other Names ________________SS# ____________(optional)

I am the ______ Patient ______ Guardian ______ Other (Please name______________)

I authorize Medical Park Family Care to release my health information as identified below **to**:
(Physician/Entity name, address & phone/fax #)

____

____

____

I authorize Medical Park Family Care to request my health information as identified below **from**:
(Physician/Entity name, address & phone/fax #)

____

____

____

(Circle one) PAPER COPY CD/DIGITAL COPY/MAIL FAX PICK-UP

Purpose of disclosure:____

I specifically authorize the use or disclosure of the following health information:

____ ALL MEDICAL RECORDS
____ Radiology Reports ____ Radiology Films from ____ to ____
____ Chart Notes ALL or from ______ to ______
____ Labs ALL or from ______ to ______
____ Billing Statements
____ Immunization records
____ Other (please list)____

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

Yes, release:____ -or- **NO DO NOT** disclose**:** ____ *HIV/AIDS related health information and/or records
Yes, release:____ -or- **NO DO NOT** disclose**:** ____ *Mental health information and/or records
Yes, release:____ -or- **NO DO NOT** disclose**:** ____ *Psychotherapy notes.

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert date, condition, or event of expiration):_____________________.

Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any given time by giving written notice. I 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. **Please allow 10 working days for processing.**

____ _________________
Signature of Patient or Patient's Legal Representative Date

____ ____
Print name of legal representative (if applicable) Relationship of Legal Representative to Patient

Picture ID #________________Released By (Employee Initials)______ Prepared By (Employee Initials) ______

The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs the authorization when the prohibition on conditioning of authorizations applies. (45 CFR§ 164.508) 4847-1353-2231, v. 1