Medical Park Family Care, Inc.

Alaska's Medical Home for 45 Years

2211 East Northern Lights Blvd., Anchorage, Alaska 99508

Authorization to Use and Disclose Restricted 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 request my health information as identified below **from**:
(Physician/Entity name, address & phone/fax #)

_____

_____

_____

I authorize Medical Park Family Care to release my health information as identified below **to**:
(Physician/Entity/General Designation, i.e. current, past, and/or future treating providers)

_____

_____

_____

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

Purpose of disclosure:_____

I understand that if this authorization includes a general designation, I may request a list of entities to which my information has been disclosed.

*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**:** ___ *Drug/alcohol diagnosis, treatment, and/or referral information

If you initialed the statement above, please provide an explicit description of the substance use disorder information that may be disclosed, including the amount of information to be disclosed.

_____

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert date 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.Federal law, 42 CFR Part 2 prohibits the re-disclosure of information disclosed pursuant to this authorization. **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) 4840-3650-7205, v. 24840-3650-7205, v. 1