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 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