MAT-SU SURGICAL ASSOCIATES

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____
Name (Last) (First) (Middle) Previous Name

_____
Address Day Phone

_____
City State Zip

_____
Date of Birth Social Security #(optional)

Release Information From:

_____
Name

_____
Address

_____
Phone

_____
Fax

Release Information To:

_____
Name

_____
Address

_____
Phone

_____
Fax

Information to be Released:

( ) Progress sheets
( ) X-Ray reports
( ) X-Ray films
( ) Discharge Summary
( ) ALL Records *
( ) Lab
( ) Operative Reports
( ) Pathology Reports
( ) History & Physical

* ALL records may include diagnoses, consultations, evaluations, tests and results, medications, treatment for all medical, psychological, or psychiatric impairments, drug and alcohol abuse/dependence, hepatitis, tuberculosis, sexually transmitted diseases, HIV, AIDS & compliance or non-compliance with treatment prescribed.

( ) Other_____

This authorization shall be in force and effect until _____or_____
(Event that relates to the patient or the purpose of the use or disclosure)
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the Privacy Officer, Stacey Smith at 2490 S. Woodworth Loop, Suite 450 Palmer, AK 99645.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (parent, guardian, ect)