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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)