AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Notice: This request is not valid unless all request information is provided.

Release From: Name: **ALASKA PEDIATRIC SPECIALTIES** **Phone**: **907.929.7337** Fax: **907.929.7330**

Address: **4100 Lake Otis Parkway, Suite 312 Anchorage, AK 99508**

Release To: Name: _____ Phone: _____ Fax: _____

Address**:** _____

_____

Patient Identification:

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

Information to Be Released (Please be specific):

Please check type of information to be released:

__ History & Physical Exam	__ Medication Sheets	__ Psychiatric Reports
__ Discharge Summary	__ Diagnosis/Procedure Note	__ Complete Medical Report
__ Consultation Reports	__ Progress Notes	__ X-ray Films/Images/CD's
__ Laboratory/Pathology Test Results	__ X-ray Reports	__ Photographs/Videotapes/CD's
__ Emergency Dept. Reports	__ Assessments/Evaluations	__ Itemized Bill
__ All Medical Records	__ Other, (specify)_____	

Receive by: __ Mail __ Pick-up __ Fax #_____

Purpose of the Request:

__ Personal (at the request of patient) __ Treatment __ Legal __ Insurance __ Government

__ Other, (specify) _____

Terms

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following **date or event:** _____.

Re-disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____