

# AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

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

**Release From:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

**Release To:** Name: **ALASKA PEDIATRIC SPECIALTIES** Phone: **907.929.7337** Fax: **907.929.7330**  
Address: **3841 Piper Street, Suite T4-020 Anchorage, AK 99508**

**Patient Identification:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Information to Be Released (Please be specific):**

**Please check type of information to be released:**

<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Medication Sheets	<input type="checkbox"/> Psychiatric Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Diagnosis/Procedure Note	<input type="checkbox"/> Complete Medical Report
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> X-ray Films/Images/CD's
<input type="checkbox"/> Laboratory/Pathology Test Results	<input type="checkbox"/> X-ray Reports	<input type="checkbox"/> Photographs/Videotapes/CD's
<input type="checkbox"/> Emergency Dept. Reports	<input type="checkbox"/> Assessments/Evaluations	<input type="checkbox"/> Itemized Bill
<input type="checkbox"/> All Medical Records	<input type="checkbox"/> 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:** \_\_\_\_\_