Confidential Care

Authorization to use and disclose health information

PATIENT IDENTIFICATION DOB:_____/_____/_____

Patient Name: _____
First Last Middle

Address: _____
City State Zip code

[ ] RELEASE FROM [ ] RELEASE TO

Confidential Care, LLC
2341 S. Fern St., Suite 200
Wasilla, AK 99654
Phone: 1.907.357.1999 Fax: 1.907.357.1990

[ ] RELEASE FROM [ ] RELEASE TO

NAME: _____

ADDRESS: _____

PHONE: _____ FAX: _____

The information released shall include documentation from treatment or examination rendered to me during the time period of _____ through _____.
Date Date

The information I wish to release shall include (please check below)

_____Discharge Summary _____Operative Records _____Medication List _____Consultation Reports
_____History & Physical _____Abstract _____Psychiatric Report _____Radiology Reports
_____Laboratory Reports _____Entire Record _____Treatment Notes _____ER Report

_____Other (specify): _____

Receive By: _____Hand delivered _____Mail to home address _____Fax to: _____

Purpose of Disclosure: _____Personal (at request of Patient) _____Treatment

_____Other (describe) _____

Terms: I understand authorizing disclosure of above information is voluntary and I need not sign this form to ensure treatment. I understand information in my health record may include records related 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 Confidential Care, LLC. *Unless revoked earlier, this authorization will expire one year from the date on which it was signed*, or upon the following date or event: _____

Redisclosure: I understand once the above information is disclosed, it may be subject to redisclosure by the recipient and no longer protected by federal privacy laws or regulations.
If signed by legal representative, relationship to patient: _____

Signature: _____ **Date:** _____