Tel: (907) 921-2221

Fax: (907) 921-2201

Release of Information

Today's Date: ___/____/____ Patient Name:_____

Dates of Service:_____Date of Birth:_____/_____/_____

Chart No._____ SSN#_____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

Patient Information is needed for:

___Continuing Medical Care ____Military ____ SocialSecurity/Disability

___Insurance ____ Personal Use ____Legal Purposes ____School or Other:_____

Information to be requested or accessed:

____History & Physical ____Consultation Report _____Lab/Imaging Reports

____Discharge/Death Summary or Other:_____

The above information may be released (specify name or title of the individual or name of organization to which records are to be released and the appropriate address):

TO:_____

Phone:_____ Address:_____

FROM:_____

Phone:_____ Address:_____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV/AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Signature:_____

Printed Name:_____

Date:_____