ALASKA INTERNAL MEDICINE + Pediatrics

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Authorization for Disclosure of Health Information

1) **PATIENT INFORMATION:**

Name Address City State Zip

Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

Name of Health Care Provider/ Plan/ Other

Address

3) **TO DISCLOSE TO:**
☐ Self, Delivery Options: ☐ Pick Up ☐ View on site ☐ Mail to address above

To be picked up by, I hereby authorize _____ to pick up my records

☐ Send to: _____
Name of Healthcare Provider/ Plan/ Other

Address OR Fax #

4) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From_____ to _____. If left blank, only information from the past two (2) years will be disclosed.

5) **INFORMATION TO BE DISCLOSED:**
☐ All medical records related to (specify condition, treatment, etc.):_____
☐ All Billing records related to (specify condition, treatment, etc.):_____
☐ Radiology films/ images (specify test):_____
☐ Specific Records/Information as follows: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED (as defined by applicable state and federal laws:
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/Developmental Disabilities

6) **EXPIRATION:** This authorization is good until the following date/event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

7) **PURPOSE** (Check all that apply – **Copy Fees MAY APPLY** ☐Further Medical Care ☐Legal Investigation/Action
☐ Insurance Eligibility/Benefits ☐ Personal (at my request) ☐ OTHER

8) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I am also aware that I may revoke this authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to use and/or disclosures: (1) already made in reliance upon this authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by federal privacy law.

9) **SIGNATURE OF PATIENT/LEGAL REP:** _____ DATE:_____
If signed by a person other than the patient, complete the following:
1. Individual is: ☐A Minor ☐ Legally incompetent or incapacitated ☐Deceased
2. Legal authority:☐A Parent* ☐ Legal Guardian ☐Next of kin/executor of Deceased ☐Active POA for Health Care

*by signing above, I hereby declare that I have not been denied physical placement of this child

For Office use only:
Signature/ID verified Yes No Completed by: _____ Date: _____