Authorization to Release Medical Information

WC AK
Women's Care of Alaska
2741 DeBarr Road, Suite C205 * Anchorage, AK 99508
(907) 279-2273 * Fax (907) 258-7705

Patient Name: _____

Date of Birth: _____/_____/_____

Current Address: _____

_____

Daytime Phone: _____

Email Address: _____

Preferred Method Of Delivery

- ☐ **Mail**
- ☐ **Fax (√ Permission Box)**
- ☐ **Pick-Up**
- ☐ **Secure Message***

***Email Address Required**

Reason For Record

- ☐ **Medical Care**
- ☐ **Individual Request**
- ☐ **Litigation**
- ☐ **Other:** _____

I AUTHORIZE MY MEDICAL INFORMATION RELEASED FROM:

WOMEN'S CARE OF ALASKA, PC
2741 DeBarr Rd, Ste C205
Anchorage, AK 99508
(907) 279-2273 – Fax (907) 258-7705

I AUTHORIZE MY MEDICAL INFORMATION RELEASED TO:

_____
Name of Facility to Receive My Information

_____
Name of MD / Provider

_____
City, State

_____
Phone Number / Fax Number

INFORMATION TO BE RELEASED

☐ **GENERAL MEDICAL RECORDS** ***(from the past TWO years)*** **or** **FROM:** _____ **TO:** _____

☐ **SPECIFIC INFORMATION ONLY, INCLUDING:**

_____ Pap Results	_____Radiology Reports	_____Labs	_____Operative Report	**Dates:** _____
_____ Mammogram Reports	_____OB / GYN Records	_____Pathology Report	_____Ultrasound Report	**Dates:** _____
_____ Office Visits	_____Medications	_____Immunizations	_____Other	**Dates:** _____

☐ **PROTECTED OR SENSITIVE INFORMATION: Initial below if you agree to release the following:**

_____The information disclosed may contain **DRUG / ALCOHOL** information. I specifically consent to disclosure of such information

_____The information disclosed may contain **MENTAL HEALTH** information. I specifically consent to disclosure of such information

_____The information disclosed may contain **HIV / AIDS** testing information. I specifically consent to disclosure of such information

_____The information disclosed may contain **GENETIC TESTING** information. I specifically consent to disclosure of such information

☐ **PERMISSION TO FAX MY RECORDS:** I specifically consent to the faxing of my medical records, when possible. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. **Initial:** _____

I authorize the above mentioned Individual / Organization to discuss with and disclose, examine, copy, prepare and furnish the information I have initialed above to any member or employee of Women's Care of Alaska.

It is acknowledged that this consent is subject to revocation at any time except to the extent the person who is to make the disclosure has already acted in reliance upon it. This consent will expire 90 days from the date of signature unless previously revoked. Further it is understood that the records disclosed pursuant to this consent may not be disclosed. A copy of this authorization will serve the same purpose as the original.

After reading the above statements, I continue to authorize the release of my Protected Health Information.

_____ _____
Signature of Patient or Patient's Legal Representative **Date**

_____ _____
Print Patient's Name or Name of Patient's Legal Representative (if applicable) **Relation to Patient**