

Authorization to Release Medical Information



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

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