AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Information:

Name:	**Date of Birth:**
Address:	**Phone:**
City/State:	**E-mail:**

Release From:		**Release To:**	
Name/Facility:		**Name/Facility:**	
Address:		**Address:**	
Phone:	**Fax:**	**Phone:**	**Fax:**

Purpose for requesting information:

Personal **Continuation of Care** **Transfer of Care**
Legal **Insurance** **Other: _________________________**

I authorize the following to be released from my medical records:

Last 6 months **Last year** **All medical records**
Other: ____

Delivery Options: Pick-up Mail Secure E-mail Secure Fax Verbal

Some records may contain sensitive/confidential information. Please *initial* below for authorization to release these specific records ______Alcohol/Substance Abuse ______HIV testing, status or care and treatment of AIDS.
______Mental Health Records ______ Sexually transmitted disease/testing ______ Genetic Records

FOR MINORS ONLY: *A minor patient's signature is required on the patient signature line to release the following information only:*

1) Conditions relating to reproductive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (age 14 and older)
2) Substance Abuse diagnosis or treatment and mental health conditions (age 13 and older).

A parent or legal guardian signature is required for the release of all other healthcare information for minors

Patient Rights: *By signing this authorization form, I understand that:*

- Request for copies of medical records are subject to reproduction fess in accordance with federal/state regulations.
- I understand the I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment).
- I must sign an authorization form in order to take part in a research study or to receive healthcare when the purpose is to create health information for a third party.
- I may revoke this authorization at in anytime in writing. If revoked, it would not affect any actions already taken by Medical Group of Alaska based upon this authorization. I may not be able to revoke this authorization if it's purpose was to obtain insurance. Two ways to revoke this authorization are: Fill out a revocation form (available from the office), *or* write a letter to the office.
- You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office disclosed health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

________________________________ ________________________________
Patient, Parent or Guardian's signature **Printed Name**
(minor patient must also sign here)

________________________________ ________________________________
Today's Date **Relationship to Patient** **Witnessed By**

This authorization will expire in 60 days from date signed or on ________________________.