mga MEDICAL GROUP OF ALASKA

AUTHORIZATION FOR RELEASE OF PATIENT PROTECTED HEALTH INFORMATION

Patient Information:

Name:	Date of Birth:
Address:	Phone:
City/State:	Social Security:

Authorization is hereby granted for release of information

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

We do not send to patient's personal fax numbers

Purpose for requesting information: ☐ Personal ☐ Continuation of care ☐ Transfer of Care ☐ Legal ☐ Insurance ☐ Other _____

I authorize the following information to be released from my records: ☐ Last 3 years ☐ Last 5 years ☐ All medical records ☐ Other _____

Delivery Options: ☐ Pick-up - MGA Location _____ ☐ Mail ☐ CD

*Some records may contain extremely confidential information. I **do consent** to the release of the following information relating to (If left blank, authorization to release information is **Not** assumed) **Patients age 13-17 must initial to consent.***

*Alcohol/Substance abuse/testing _____(initials)
*Mental Health conditions/Psychotherapy notes and Psychological Evaluations _____(initials)
*HIV testing, status or care and treatment for AIDS _____(initials)
*Sexually transmitted disease/testing _____ (initials)
*Genetic records _____ (initials)

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

- Requests for copies of medical records subject to reproduction fees in accordance with federal/state regulations.
- I understand I do not have to sign this authorization in order to receive health care benefits (treatment, payment or enrollment).
- I do have to sign an authorization form: To take part in a research study or to receive health care when the purpose is to create health information for a third party.
- I may revoke this authorization 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 discloses 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 *(Patient's age 13-17 must also sign)* | Printed Name

_____ _____
Today's Date | Relationship to Patient | Witnessed by

This consent will expire on _____ or 60 days after date signed.