AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

mga MEDICAL GROUP OF ALASKA
Algone Interventional Pain Clinic
Capstone Family Medicine
Capstone Urgent Care
Empower Physical Therapy
Our Doctor's Pharmacy

This form must be completed in its entirety to ensure request fulfillment. Please address all areas as applicable to your request.

Patient Information Name:	Date of Birth:
Complete Address:	Phone: Email:

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

PURPOSE FOR REQUESTING INFORMATION (please mark each option that applies)					
	Personal Use		Continuation of Care		Transfer of Care
	Legal Use		Insurance Use		Other (please specify):

I AUTHORIZE THE FOLLOWING TO BE RELEASED FROM MY MEDICAL RECORDS NOTE: Once we receive your records from another source, we cannot give them to you. We advise that you always keep your own copy for your future needs.					
	Last 6 months of records.		Last Year of records.		All medical records.
	Other (please specify):				

******* Some records may contain sensitive/confidential information and require a separate permissions acknowledgement. Please initial below for authorization to release these specific records.***					
	Alcohol/Substance Abuse Records		Genetic Records		Mental Health Records
	Sexually transmitted disease or testing records.		HIV testing, status or care and treatment of AIDS.		

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

LEGAL NOTIFICATIONS

Minors Only: *A minor patient's signature is required to release the following specific information.*
Conditions relating to productive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (pertains to minors age 14 and older). • Substance Abuse diagnosis or treatment and mental health conditions (age 13 and older).

Patient Rights: *By signing this authorization form, I am demonstrating I have read and understand the following information.*
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 understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, **42 C.F.R. Part 2**, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), **45 C.F.R. pts 160 & 164**, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. • I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. • 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 Signature (even if a minor):	**Parent/Guardian Signature (if minor patient):**	
Patient Printed Name: **Relationship to Patient:** Self	**Parent/Guardian Printed Name:** **Relationship to Patient:**	
Today's Date:	**Today's Date:**	
This authorization will expire in 60 days from date signed or on ______________________________.	Witnessed By (Name/Title):	Date:

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3066 E. Meridian Park Loop, Suite 3
Wasilla, Ak 99654
P: 907 357-7710 F: 907 357-7720

Invoice for Medical Records# ________________________

PATIENT:__________________________________ **DATE:**________________________________

We have received your request for your medical records. To cover the cost of copying and/or mailing, Alaska State Law allows for a reasonable charge.
MGA accepts the following forms of payment: cash, check or credit card

Record charges are as follows:

Pages#_________________ Amount#_____________________

1-25 pages: FREE
26-50 pages: $20.00
51-75 pages: $25.00
76-100 pages: $30.00
101+ pages: $40.00
DISC FORMAT: $15.00

PAYMENT INFORMATION : Visa Mastercard Cash Check#

Name on Credit Card ______________________________**Credit Card No.**_________________________

Exp. Date__________________ **3 Digit Code**_______________ **Billing Zip Code**

Card Address____

City_________________________ **State**____________________**Zip**_____________________

____ ______________________________

PATIENT NAME (please print) **DATE:**

____

PATIENT/GUARDIAN SIGNATURE

__________________________________ ___________________________________

TELEPHONE **EMAIL ADDRESS**