General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name:____

Address: ____

Phone: ______________________ SSN: _______________________ Date of Birth: ___________________

I authorize the custodian of records of: ____or other person/entity (specifically described) to disclose/release the following information (check all that apply).

- All records
- Laboratory/pathology records
- X-Ray/radiology records
- Mental Health Records
- Abstract/Summary
- Pharmacy/Prescription records
- Other (describe specifically)

*Note: If these records contain any information from previous providers of information about HIV/AIDS status, cancer diagnosis drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): _____________________________________

Please send the records listed above to (use additional sheets if necessary)

Name:____

Address:____

Phone: ___________________________________ Fax:____

The information may be used/disclosed for each of the following purposes:

- Transferring Physician
- For continued health care
- For payment/insurance
- Attorney/Lawyer Request (which a fee will apply)
- Other:

The authorization shall expire no later than: _____/_____/_____ or upon the

following event: ____

(whichever is sooner) and may not be valid for greater than one year from the date of signature for medical records. I understand that after the custodian of the records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

______________________________	______________________________
Signature of patient (or patient's representative)	Date
______________________________	______________________________
Printed name of patient representative	Representative's authority to sign for patient (ie. Parent, Guardian, power of attorney for healthcare)

You have the right to revoke this authorization, except to the extent the custodian of records has relied on it by sending your written request to the Privacy Liaison at 950 E. Bogard Rd. Ste 212 Wasilla, AK 99654