Medical Park Family Care

Alaska's Medical Home for over 50 years

2211 East Northern Lights Blvd., Anchorage, Alaska 99508

Authorization to Use and Disclose Health Information

Patient Name (Please Print) _____

Date of Birth_____**Phone #** _____**Other Name(s)** _____

I am the: ❑ Patient ❑ Guardian ❑ Other (Please name _____)

I hereby authorize Medical Park Family Care to: ❑ **Release or** ❑ **Request** my health information as identified below to: (One form per location)

Physician Name/Entity _____

Address _____

City, State, Zip Code _____**Phone/Fax #**_____/_____

❑ **Paper Copy** ❑ **CD/Digital Copy** ❑ **Mail** ❑ **Fax** ❑ **Email** ❑ **Pick Up**

Purpose of disclosure: _____

I specifically authorize the use or disclosure of the following health information:

❑ Radiology Reports ❑Radiology Films	**Last 3 years** OR from _____ to _____
❑ Chart Notes	**Last 3 years** OR from _____ to _____
❑ Lab Results	Last 3 years OR from _____ to _____
❑ Billing Statements	
❑ Other (please list) _____	

Unless revoked earlier, this authorization will expire in 180 days from the date of signing.

Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any time by giving written notice. I understand that Medical Park Family Care may not condition the Patient's healthcare on this authorization except for (i) research-related treatment; or (ii) if the purpose of the health care is to create information for disclosure, e.g. for employment physicals or similar situations.

I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information describe above may be re-dsiclosed and no longer protect by these regulations.

Please allow 10 working days for processing.

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

_____ _____

Print name of legal representative (if applicable) **Relationship** of Legal Representative to Patient

Picture ID # _____Released by (Employee initials) _____ Prepared by (employee initials) _____