



Liberty Village, 9138 Arlon Street, Suite A-2
Anchorage, AK, 99507

Main: (907) 248-2482
Fax: (907) 248-0045
www.myHealthClinicAK.com

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

Patient Information

Last name: _____ MI: ____ First name: _____

Address: _____ Phone: _____

City: _____ State: ____ Zip: _____ SS#/DL#: _____ Birth Date: _____

Records Released From

Name (i.e. Health Facility, Provider...) _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Records Released To

Name (i.e. Health Facility, Provider, Insurance Company, Lawyer...) _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Information to be Released/Obtained

By initialing the spaces below, I authorize to release/obtain the following specific medical records, if such records exist:

- _____ Complete medical record
- _____ Lab reports
- _____ Diagnostic imaging reports
- _____ Immunization records
- _____ Physical therapy records
- _____ Billing records
- _____ Other: _____
- _____ Clinic records pertaining to treatment of: _____

By initialing the spaces below, I authorize to release/obtain the following otherwise privileged information, if such records exist:

- _____ HIV/AIDS/AIDS-related illnesses
- _____ Drug/alcohol treatment/evaluation
- _____ Developmental disabilities
- _____ Psychotherapy records

(If this authorization is for the use and/or disclosure of psychotherapy records, it cannot be combined with any other authorization).

_____ This authorization is limited to the following time period: _____

Purpose or Need for Disclosure

Information requested for following purpose: Further Patient Treatment Patient Billing
 Legal Representation Other _____

I have read and understand this authorization and had a chance to ask questions about the disclosure of the health information. I authorize release of my medical records in accordance with the specifications listed above. A photocopy of this consent shall be valid as the original.

Signature of Patient or Authorized Person by Law: _____ Date: _____

Over for additional information

Additional Information Regarding Disclosure of Patient Medical Information

- **Revocation.** I have the right to revoke this authorization, in writing, at any time. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this consent will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
- **No obligation to sign.** I am under no obligation to sign this form, and I may refuse to do so. Except as permitted under applicable law, myHealth Clinic, LLC may not refuse to provide you treatment or other health care services if you refuse to sign this form.
- **Right to inspect.** I may inspect or copy any information to be used or disclosed under this authorization.
- **Re-release.** I understand that, if a person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is not and is no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.