Acute Family Medicine Clinic

acutefamilymedicine.com

AUTHORIZATION TO: RELEASE / OBTAIN MEDICAL RECORDS

11470 Business Blvd Ste 100 Eagle River, Alaska 99577
Phone: 907-622-4325 Fax: 907-622-4326

Patient Name_____ Date of Birth_____

I authorize _____ to release records to:

Name: _____
Address: _____
Phone: _____ Fax: _____

Information requested for the following purpose: □ Patient Treatment □ Payment/Billing □ Healthcare Operation

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

___ Entire medical record (all information)
___ Laboratory reports _____ Diagnostic imaging reports ____Pathology reports
___ Clinical office chart notes
___ Medical reports needed for continuity of care
___ Physical therapy records
___ All hospital records (including nursing records and progress notes)
___ Transcribed hospital records
___ Dental records
___ Billing statements
___ Other: _____
___ This authorization is limited to the following treatment:_____
___ This authorization in limited to the following time period:_____
___ This authorization is limited to workers' compensation claim for injuries of:_____
___ HIV/AIDS related records (must be initialed to be included in other documents)
___ Drug/alcohol diagnosis, treatment or referral information is to be disclosed." Please provide a specific description:_____
___ Psychotherapy notes. (If this authorization is for the use and /or disclosure of psychotherapy notes, it cannot be combined with any other authorization).

_____

● I understand this authorization may be revoked at any time by giving written notice to AFMC. The only exception is when action has been taken in reliance on the authorization.
● Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.
● I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.
●I understand that, if a person or entity receiving 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 not and 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.

_____ _____
Signature of patient or authorized person by law Date

_____ # of pages copied _____ Records Fee _____ Date Mailed / Faxed / Picked Up
Records sent by: _____ per Dr. Dan Coverdell's consent.