Authorization for Release Of Health Information

ENT Specialists OF ALASKA

Patient name: _____ Date of birth: _____

I authorize release of medical records from:

_____

Phone/fax: _____

To be released to:

_____

Phone/fax: _____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such information or record exist:

____ Please send the entire medical record (all information) to the above-named recipient

____ All hospital records (including nursing records and progress notes)

____ Medical records needed for continuity of care

____ Emergency and urgent care records

____ Diagnostic imaging reports

____ Clinician office chart notes

____ Billing statements

____ Laboratory reports

____ Pathology reports

____ Operative reports

____ Other: _____

_____

**The following items must be initialed to be included in the use or disclosure of other health information:

____ ** HIV/AIDS-related information and/or records

____ ** Mental health information and/or records

____ ** Genetic testing information and/or records

____ ** Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal regulations, the information described above may be redisclosed and no longer protected under the Federal Substance Abuse Confidentiality Requirements. I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, providing that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked in writing earlier, this authorization will expire 180 days from the date of signing.

_____ _____ _____

Patient or legal representative signature | Printed name of signer | Date

_____ _____

Witness signature | Date