# Authorization to Use and/or Disclose Health Information

301 W Northern Lights Blvd, Suite 600 Anchorage, AK 99503 • P 907-771-3500 • F 907-771-3550 • www.akortho.com

**Patient Name: _____ D.O.B. _____ SS#_____**

I authorize _____

_____

_____

***(Name, Address, Phone & Fax # of Provider you are requesting records from)***

To disclose my health information as identified below to:

**Alaska Orthopedic Specialists**
**301 W Northern Lights Blvd, Suite 600**
**Anchorage, AK 99503**
**(907) 771-3500 | Fax (907) 771-3550**

By ***initialing*** the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____Please send the entire medical record (all information) to the above named recipient.

**OR**

_____All hospital records (including nursing records & progress notes)
_____Operative reports
_____Medical records needed for continuity of care
_____Most recent five-year history
_____Emergency and urgent care records
_____Other: _____

_____Office chart notes
_____Laboratory reports
_____Pathology reports
_____Diagnostic imaging/X-ray reports
_____Billing statement/Full account ledger

* The following items must be initialed to be included in the use or disclosure of other health information:
_____*HIV/AIDS related health information and/or records
_____*Mental health information and/or records
_____*Genetic testing information and/or records
_____*Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

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

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Medial Records Department at the provider listed above. Unless revoked earlier, this authorization will expire **180 days** from the date of signing or _____.

**(Expiration Date)**

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 also 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 described above may be re-disclosed and no long protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
**Signature of Individual or Individual's Legal Representative** **Date**

_____ _____
**Print Name of Legal Representative (if applicable)** **Relationship to Individual**