



# Authorization to Use and/or Disclose Health Information

4015 Lake Otis Parkway, Suite 201 Anchorage, AK 99508 • Phone 907-771-3500 • Fax 907-771-3550 • [www.akortho.com](http://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**  
**4015 Lake Otis Pkwy, Ste. 201**  
**Anchorage, AK 99508**  
**(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) | ____ Office chart notes                    |
| ____ Operative reports   | ____ Laboratory reports                    |
| ____ Medical records needed for continuity of care                     | ____ Pathology reports                     |
| ____ Most recent five-year history                                     | ____ Diagnostic imaging/X-ray reports      |
| ____ Emergency and urgent care records                                 | ____ Billing statement/Full account ledger |
| Other: _____   |  |

\* 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**