Anchorage Fracture & Orthopedic Clinic
The Strength of Experience
a division of OrthoAlaska

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# Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____ Day Phone: _____
Address: _____ City/State/Zip: _____

**I authorize Anchorage Fracture & Orthopedic Clinic to release information to:**

Person/Facility: _____ Phone: _____ Fax: _____
Address: _____ City/State/Zip: _____

**Type of information to be disclosed:** Date(s) of Treatment: _____ Body Part: _____

- ☐ Copy of MRI Image ☐ Copy of X-Ray Image
- ☐ Copy of entire medical record as allowed by law
- ☐ Specific information (select all that apply):
  - ☐ Procedure Note ☐ History & Physical ☐ PT/OT Therapy Notes
  - ☐ Lab Test Result ☐ MRI Report ☐ X-Ray Report
  - ☐ Other _____

**The purpose of this disclosure is:** (check one)
☐ Continuation of Care ☐ Personal ☐ Legal ☐ Transfer of Care ☐ Request of the Individual

Preferred Delivery Method:
- ☐ Please call me when records are ready. I will allow 48 hours for preparation before pick-up.
- ☐ Please mail my records to the address of recipient (required if CDs of images are involved).
- ☐ Please fax my records to the intended recipient.

**Authorization:** I understand this authorization will expire on _____

**If I do not specify an expiration date, this authorization will expire one year from date signed.*

I understand that:

- Authorizing the disclosure of this information is voluntary. My right to treatment, payment, enrollment or eligibility for benefits is not contingent on signing this form.
- I have the right to revoke this authorization at any time by submitting a *written* request to the address provided at the top of this form. I understand that this will not apply to information that has already been released as a result of this authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the person or facility listed above as receiving this information is not covered by federal health privacy regulations, the released information may be re-disclosed and may no longer be protected by federal or state law.
- The patient's first copy is complimentary but there may be a charge for requested records after that, or for medical records released to third parties.

Signature of patient or representative: _____ Date: _____

Relationship to patient & authority (if requestor is not the patient) _____