Anchorage Fracture & Orthopedic Clinic
The Strength of Experience

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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, and 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): _____

Anchorage Fracture & Orthopedic Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.