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Anchorage, AK 99508
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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) ________________________________

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.