ANCHOR
MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ Social Security Number: _____

I authorize (Clinic or Physician): _____
Address: _____
Phone Number: _____ Fax Number: _____

To release records to: Anchor Medical Group
Address: 2841 DeBarr Road, Suite 24, Anchorage, AK 99508
Phone Number: 907-279-4953 Fax Number: 907-334-9667

To be: ____ Faxed _____ Picked up

Information to be Disclosed:
____ Complete Chart
____ History and Physical
____ Discharge Summary
____ Laboratory Reports
____ Radiology Reports
____ Emergency Reports
____ Consultations
____ Pathology Reports
____ Other (please list): _____

For the purpose of (*check all that apply*):
____ Treatment
____ Payment (Insurance Claim)
____ Health Care Operations
____ Personal Records
____ Legal Request
____ Worker's Compensation
____ Other:_____

I acknowledge that the information to be released MAY INCLUDE material that is protected by law. My initials and my signature below authorize release of the following type of information to the extent permitted by law:

(*Initial*)_____Drug/Alcohol Abuse (*Initial*) _____Mental Health (*Initial*) _____HIV Information

I understand that this disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this release in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 165.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may no longer be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at Anchor Medical Group. This consent is subject to revocation at any time except to the extent that the department is to make the disclosure has already taken action in the reliance on it. If not previously revoked, this consent will terminate upon_____ (date), not to exceed 90 days.

Signature: I have read this authorization, I have had the opportunity to ask questions, I understand the authorization, and I am freely signing this authorization.

Patient Name: _____ Signature: _____

Date: _____ Relationship to Patient: _____

Erin Royal, MD • Hannah Hawkins, MD • Juliana Shields, MD

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