ALASKA WOMEN'S HEALTH, PC
3260 PROVIDENCE DR. STE 322
ANCHORAGE, AK 99508
TELEPHONE: (907) 563-5151 FAX: (907) 339-1693

RELEASE OF MEDICAL RECORDS TO ☐ SELF ☐ ANOTHER PRACTICE ☐ AWH, PC

PATIENT'S NAME: _____ **DATE OF BIRTH:** _____

CURRENT ADDRESS: _____ **CURRENT TELEPHONE:** _____

_____ **SOCIAL SECURITY NUMBER:** _____

GUARANTOR'S NAME: (if different from patient) _____

I hereby authorize Alaska Women's Health, PC to release medical records containing alcohol/drug records of the above named patient to/from:

Name: _____

Address: _____

City, State, Zip: _____

Information requested to be released:

☐ Progress Notes ☐ Laboratory Reports ☐ Consultation Reports ☐ Hospital Records ☐ X-Ray Reports ☐ Surgical Reports

☐ All information held within the record ☐ Other _____

SPECIFIC AUTHORIZATIONS

DRUG AND ALCOHOL: I UNDERSTAND that my records may contain information regarding diagnosis and/or treatment for drug and/or alcohol abuse. I give my specific authorization for these records to be released. **[_____ Patient Initials]**

AIDS/HIV: I UNDERSTAND that my records may contain information regarding testing, diagnosis and/or treatment of HIV/AIDS and/or of sexually transmitted diseases. I give my specific authorization for these records to be released. **[_____ Patient Initials]**

PROTECTED HEALTH INFORMATION: I UNDERSTAND THAT my records may contain individually identifiable health information. I give my specific authorization for these records to be released. **[_____ Patient Initials]**

REVOCATION AND EXPIRATION

I UNDERSTAND THAT I may cancel this authority at any time in writing, except to the extent that action has been taken in reliance on it. Unless cancelled earlier by me, this authorization will expire on the date the Protected Health Information is released either to my directed representative or me by being faxed as directed or by being placed in the United States Postal System as directed.

RE-DISCLOSURE AND HOLD HARMLESS

My signature below constitutes my specific consent for purposes of 42 C.F.R. Part 2 regarding the disclosure of information regarding my confidential alcohol and drug abuse patient records, if any. I further understand that my individually identifiable health information may be redisclosed to individuals or organizations not subject to the Health Insurance Portability and Accountability Act of 1996. I agree to hold this facility, its employees and the attending provider harmless for the release of records pursuant to this authorization.

COPY EFFECTIVE AS ORIGINAL

I am willing that dated and signed photocopies of this authorization have the same force and effect as an original. I understand that I have the right to receive a copy of this authorization. **I understand that copies made beyond the initial copy to myself will have a charge of .25¢ per page. I understand that copies of my records may take up to 14 days to process.**

Signed: _____ Request Date: _____

Signed: _____ ☐ Driver's License or other ID furnished
Alaska Women's Health, PC Witness Signature

For tracking purposes please check all boxes that apply:

- ☐ Leaving the State or Anchorage area
- ☐ Personal reasons, plan to stay with practice
- ☐ Transferring permanent care to another local provider because: **(If checked, please indicate reason(s) below)**
- ☐ Desire private care only
- ☐ Coordination of care
- ☐ Financial reasons (fees too high, unable to pay, no insurance)
- ☐ Provider problems (too busy, personality, attitude, rude, etc.)
- ☐ Staff Problem (personality, attitude, abrupt, rude, non-caring, etc.)
- ☐ Other, please specify, _____
- ☐ Seeking a second opinion, but plan to return to practice for care
- ☐ Referred to AWH for treatment, now returning to original provider

OFFICE USE ONLY

CONSENT TO RELEASE

Provider _____ Director _____

RELEASE DATE: _____

Initials: _____