Alaska Urgent Care

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name ______________________________ Previous Name (if any): ____________________

DOB: ____/____/____ Phone ____________________ Social Security No.: ____________________

I give authorization for the use or disclosure of the above individual's health information as described below:

1) **Released from:** ☐ **Alaska Urgent Care** ☐ Dimond Medical Clinic ☐ Other

Facility Name ____

Address ______________________________ State ________ Zip ________

Phone # ____________________ Fax # ____________________

Released to: ☐ **Alaska Urgent Care** ☐ Dimond Medical Clinic ☐ Other

Name ____

Address ______________________________ State ________ Zip ________

Phone # ____________________ Fax # ____________________

2) Type of information to be used or disclosed (check all that apply)

☐ All Medical Record types ☐ History & Physical ☐ Progress Notes
☐ Lab Results ☐ Radiology Reports ☐ Consultation Reports
☐ Other ____

3) Including any of the following specific confidential information (check all that may apply)

☐ HIV/AIDS ☐ Mental Health ☐ Substance Abuse Treatment ☐ Reportable STDs

4) Dates of service requested (check one)

☐ All Medical Records
☐ Past 12 months
☐ The specific time period from ____________________ to ____________________

EXPIRATION

This authorization expires on ____________________, or 90 days from the date of signature. I understand I have the right to revoke this consent any time in writing except to the extent that the information has already been released.

SIGNATURES

____ ____________________
(Signature of Patient or Legal Guardian*) (Date)
* If legal representative, relationship to patient ____________________Proof of Relationship ____________

____ ____________________
(Witness Receiving Request) (Date)