9500 Independence Drive Suite 900
Anchorage, AK 99507
Phone (907) 522-1341 Fax (907) 522-1343
E-mail address: ipms@ipmsak.net
Web address: www.ipmsak.com

CONSENT TO RELEASE INFORMATION

Patient Name (Please Print) ____

Date of Birth ____________ **Other Names** ______________________________ **SS#** _____________________________

I am the ___ Patient ___ Guardian ___ Other (Please Name) ________________________________

I authorize Medical Records to be released:
FROM: ____
____

to use and/or disclose my health information as identified below
TO: (Physician Name/Office Name, Address, Phone Number, Fax Number) ______________________________
____
____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

- ____ ALL MEDICAL RECORDS
- ____ Only recent five-year history
- ____ Chart notes ALL or from ______________ to ______________
- ____ Shot Record
- ____ Labs ALL from ______________ to ______________
- ____ X-ray/ultrasound reports ALL or from ______________ to ______________
- ____ Billing statements
- ____ Other (please list) ____

If you need a copy of an X-Ray contact our Radiology department at 365-5245!

****PLEASE INITIAL, the items below, for such info to be included in the use or disclosure of other health information:**
Federal regulations require a description of how much of what kind of information is disclosed. Federal law prohibits the re-disclosure of such information, only with authorization:

Must Be Completed

- ____**HIV/AIDS related health information and/or records
- ____**Mental health information and/or records
- ____**Drug/alcohol diagnosis, treatment, and/or referral information

Please check the reason for release below; and provide a date which the info is needed by: _______________

__Moving out of area	__Rehab/Disability	__Insurance	__2nd opinion
__Personal File	__Legal	__Transferring Care	__Other medical care

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert date or event of expiration): ______________________________.

Except to the extent that action has already been taken in reliance upon the authorization, I understand I may revoke this authorization at any time by written notice to Suzi, C., Privacy Officer.

I understand that if the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

******* IMPORTANT NOTICE*******

Patients may receive the first copy of medical records free, excluding charts in storage. Copies of medical records up to 15 double-sided pages will be assessed a fee of $35. Copies over 15 pages will be assessed a fee of $35 plus $.25 per double sided page. Charts in storage will cost $10 plus charges to copy. Payment is required before copies are sent out.

PLEASE ALLOW 10 WORKING DAYS FOR PROCESSING

______________________________ ______________________
Signature of Patient or Patient's Legal Representative Date

______________________________ ______________________
Print name of Legal Representative (If Applicable) Relationship of Legal Representative to Patient

Type of Picture ID verified ______________________ **Employee Initials** ______________
Patient Received ______________________________ **Date** ______________

Rev. 8/2016