Independence Park Medical Services

PERMISSION TO RELEASE PERSONAL HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

I authorize Independence Park Medical Services to release my personal health information "PHI" to the following individual(s):

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

By signing below, you agree that IPMS may release "PHI" to the above individual(s).

This release will remain in effect for one year from the date signed below.

This release does not give permission to the delegated individual(s) to:

- Ask for a complete copy of your medical records, a signed Release of Information is required.
- Have access to any medical records that have been noted as confidential.
- Pick-up prescriptions for controlled medications. Verbal permission must be given each time a prescription is to be picked up by someone other than yourself and must be documented in your chart.

If you wish to cancel this release you must do so in writing directed to:

Front Desk Staff
Independence Park Medical Services
9500 Independence Drive, Ste 900
Anchorage, AK 99507

If you have any additional questions please call (907) 522-1341

Signature: _____ **Date:** _____