Independence Park Medical Services

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 ONLY
____ Labs ALL or from _____ to _____
____ X-ray/ultrasound reports ALL or from _____ to _____
____ Billing statements ALL or from _____ to _____
____ Other (please list) _____

*****If you need a copy of an X-Ray Image(s) Please Contact our Radiology Department!***

****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 365 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 Privacy Officer/Office Manager.

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. Paper copies of medical records fees start at $35 and may be charged up to $75, depending on the volume of records requested. An additional $10 retrieval fee applies to charts stored off-site. Payment is required before copies are released.

PLEASE ALLOW 30 WORKING DAYS FOR PROCESSING

Under the HIPAA Privacy Rule, a covered entity must act on an individual's request for access no later than 30 calendar days after receipt of the request. If the covered entity is not able to act within this timeframe, the entity may have up to an additional 30 calendar days, as long as it provides the individual – within that initial 30-day period – with a written statement of the reasons for the delay and the date by which the entity will complete its action on the request. See 45 CFR 164.524(b)(2) *

_____ _____
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. 8/2026