ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

3831 Piper Street Suite S450 Anchorage, Alaska 99508 Phone 907-258-6999 Fax 907-258-6247

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization affects your rights in the privacy of your Protected Health Information. Please read it carefully before signing.

Patient Name: ___________________________ SSN: __________________________
Date of Birth: ___________________________ Phone: _________________________
Address: _______________________________ Fax: __________________________
____

I authorize **Anchorage Neurosurgical Associates, Inc.**, to
☐ **disclose** my health care information to: ☐ **obtain** my health care information from:

Name: ____
Organization: ____
Address: ____
City, State, Zip code: ____
Phone (include area code): (____)__________________ Fax: (____)__________________

Release the following information:

☐ Progress Notes/Treatment Plan ☐ Op Report(s)
☐ X-ray/Radiology Report(s) ☐ Consultation(s) ☐ **Entire Medical Record**
☐ Laboratory/Pathology Report(s) ☐ Itemized Billing
☐ Other: ____

Reason for this Request:

☐ At my request ☐ Other: ____

Expiration Date of Request: This authorization will remain in effect for one (1) year, unless I have checked or filled in a different expiration date.

☐ None ☐Other: ____

***Note: You are hereby authorizing disclosure of all information in the items you have checked above, including information from previous providers and information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, sexually transmitted disease, or mental health contained in the items checked above.**

TURN OVER

I understand that:

- After the custodian of records discloses my Protected Health Information, it may no longer be protected by federal privacy laws (HIPAA). State or other federal law may require the recipient to obtain your authorization before further disclosure.
- I further understand that this authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
- I have the right to revoke this authorization in writing at any time.
- I have the right to a copy of this form upon request.

By signing below I represent and warrant that I have authority to sign this document and to authorize the use or disclosure of Protected Health Information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this Protected Health Information.

____ Date: ______________________

Signature of Patient or Legal Representative

____

If signed by Legal Representative, relationship to patient

FOR OFFICE USE ONLY

INTAKE BY: __________ PROCESSED BY: __________

RECORDS WERE: ☐ MAILED ☐ FAXED DATE: ________________