



RELEASE OF MEDICAL INFORMATION

Patient Full Name: _____

Date of Birth: _____ Social Security: _____

I Request Medical Information:

[] From

[] To

Name: _____

Address: _____ State/Zip: _____

Phone Number: _____ Fax Number: _____

Dates Seen: _____

I. My Authorization

You may use or disclose the following health care information for my continued care:

- Complete Records Chart Notes Imaging Results
- History & Physical Lab Results Medication List
- Other (please specify): _____

Some medical records may contain extremely confidential information. I do consent to the release of the following information relating to (if left blank, authorization to release information is NOT assumed)

Drug or alcohol abuse: _____ (initials) HIV testing, infection status or care and treatment for AIDS: _____ (initials)

Mental health conditions: _____ (initials)

Please disclose records to: **Frontier Family Medicine, LLC Fax: 907-373-3948**
 Other: _____

This consent will expire on _____ or 60 days after the date below.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form: to take part in a research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Frontier Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form or write a letter to the office. The form is available from the office. You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office discloses health information, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

Patient, Parent or Guardian's Signature

Print Name

Today's Date

Relationship to patient

Witness
