Northwoods Family Medicine
1301 E Palmer-Wasilla Hwy #400
Wasilla, AK 99645
Records
(907)357-9400 Phone
1-877-547-5901 Medical Records Fax

Authorization to Disclose
Medical Information and Request for Medical

Date: ___/___/___

Patient Name: _____ Previous name: _____

Date of Birth: ____/____/_____ Social Security: _____

I hereby authorize my medical records for dates of treatment ____/____/____ OR

records from ____/____/____ to ____/____/____ to be released

From: _____ To: _____
(Please circle one)

Documents requested:
___1.Chart notes
___2.Lab reports
___3.History & physical
___4.Radiology reports
___5.X-Ray films
___6.E.R. reports
___7.Other (specify)

For the purpose of:
___1.Further treatment
___2.Insurance claims
___3.Workers compensation
___4.Legal request
___5.Other (please list)_____
_____
_____

I acknowledge that the information to be released MAY INCLUDE material that is protected by FEDERAL LAW. My initials and signature below authorize release of the following type of information:

_____Drugs/Alcohol abuse _____Mental Health _____HIV/AIDS

HIPAA PRIVACY RULE CONSENT, INFORMATION DISCLOSURE AND AUTHORIZATION

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPAA) and will be used only with patient consent. I hereby authorize Northwoods Family Medicine to further information to other providers, healthcare or treatment facilities.

This consent will expire on ____/____/____ or 90 days from date stated above, whichever comes first.

I am the ____Patient ____Parent ____Guardian ____Designee

_____ _____

Patient Signature

Parent, Guardian, Designee