ANCHORAGE MEDICAL & SURGICAL CLINIC, LLC
718 K Street, Anchorage, AK 99501 (907) 272-2571 FAX 272-6751

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

By signing this authorization, I authorize: ANCHORAGE MEDICAL & SURGICAL CLINIC

(Full name and address) 718 K STREET
ANCHORAGE, ALASKA 99501

to use and/or disclose certain protected health information (PHI) about me as described below:

Specific description of the information to be used or disclosed including the dates of service(s):

Chart notes last 3 years _____ X-Ray: Report _____ Film _____ Lab Report _____

Other _____

Dates of Service _____

The protected health information will be used and/or disclosed for the following purpose:

	Personal records		Transferring permanent care to another provider
	Other _____		Other _____

Persons to whom the use or disclosure may be made: _____

(Full name and address) _____

_____

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulation, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Anchorage Medical & Surgical Clinic LLC in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Anchorage Medical & Surgical Clinic LLC before my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign will in no way affect my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on _____
(Expiration Date or Defined Event)

_____ _____
Patient Signature Date

Records will be provided in PDF format on a disc unless otherwise requested. _____

For Personal Representative:

Print name of Personal Representative _____Relationship _____

_____ _____
Signature of Personal Representative Date