RELEASE OF MEDICAL INFORMATION

PATIENT NAME_____
DATE OF BIRTH_____

SOCIAL SECURITY #_____

I AUTHORIZE_____TO RELEASE RECORDS TO:

ALASKA OB-GYN ASSOCIATES, LLC
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MAIL:____ FAX:_____PICK-UP:_____

WHEN NEEDED: _____

INFORMATION REQUESTED: FOR THE PURPOSE OF:

_____HISTORY & PHYSICAL
_____DISCHARGE SUMMARY
_____LABORATORY REPORTS
_____RADIOLOGY
_____CLINIC REPORTS
_____EMERGENCY ROOM REPORTS
_____CONSULTATION
_____PATHOLOGY REPORTS
_____COMPLETE CHART
_____OTHER (PLEASE SPECIFY BELOW)

_____FURTHER TREATMENT
_____INSURANCE CLAIMS
_____WORKERS COMPENSATION
_____LEGAL REQUEST
_____PERSONAL RECORDS
_____OTHER (PLEASE SPECIFY)

I ACKNOWLEDGE THAT THE DATA TO BE RELEASED MAY INCLUDE MATERIAL THAT IS PROTECTED BY FEDERAL LAW. MY INITIALS AND MY SIGNATURE BELOW AUTHORIZE RELEASE OF THE FOLLOWING TYPE OF INFORMATION.

_____DRUG/ALCOHOL ABUSE _____MENTAL HEALTH _____HIV TESTING

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE DEPARTMENT THAT IS TO MAKE THE DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON IT. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE UPON:_____(DATE). THIS RELEASE IS GOOD FOR THE TERM PERIOD OF ONE (1) YEAR, UNLESS OTHERWISE DIRECTED BY THE PATIENT.

SIGNATURE:_____**PRINTED NAME:**_____

RELATIONSHIP TO PATIENT: _____

DATE: _____WITNESS: _____

#OF PAGES OR FILMS: _____COMPLETED BY: _____

DATE PICKED UP: _____ BY(INITIALS) _____ DATE: _____