Name:
Chart:
Date:

Alaska Fracture & Orthopedic Clinic
4100 Lake Otis Pkwy, Suite 220 / Ph: 907.563.3145 Fax: 833.464.5196

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information:	Patient Full Name (print):	DOB:
	Address (City, State, and Zip Code):	
	Phone Number:	Email Address:

Release From:	☐ Alaska Fracture and Orthopedic Clinic OR:	
	Name of Provider/Clinic/Organization:	
	Address (City, State, and Zip Code):	
	Phone Number:	Fax Number:

Release To:	☐ Alaska Fracture and Orthopedic Clinic OR:	
	Address (City, State, and Zip Code):	
	Phone Number:	Fax Number:

Information to be Released:	Dates of Treatment:	Body Part:		Delivery Method:
	☐ Entire Medical Record, including CD images (as allowed by law)			☐ Pick up
	☐ Entire Medical Record, not including CD images (as allowed by law)			☐ Mail
	Specific information: (select all that apply)			☐ Fax
	☐ Procedure Note	☐ History & Physical	☐ PT/OT Therapy Notes	Date Needed By:
	☐ Lab Test Results	☐ MRI Report	☐ XRAY Report	
	Other:			

Purpose for Release: ☐ Personal ☐ Transfer of Care ☐ Continuation of Care ☐ Insurance/Disability ☐ Legal ☐ Other

I understand that:

- Authorizing the disclosure of this information is voluntary. My right to treatment, payment, and enrollment or eligibility for benefits is not contingent on signing this form.
- I have the right to revoke this authorization at any time by submitting a ***written*** request to the address provided at the top of this form. I understand that this will not apply to information that has already been released as a result of this authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the person or facility listed above as receiving this information is not covered by federal health privacy regulations, the released information may be re-disclosed and may no longer be protected by federal or state law.
- The patient's first copy is complimentary, but there may be a charge for requested records after that, or for medical records released to third parties.

I understand this authorization will expire on: _____

*If I do not specify an expiration date, this authorization will expire one year from date signed.

Signature of Patient or Representative: _____ Date of Signature: _____

Relationship to Patient & Authority (if requestor is not the patient): _____

* Please note: Records will be released within 72 hours, but if your request is urgent, we will do our best to accommodate your timeframe. Alaska Fracture & Orthopedic Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, or sex.