Alaska Center for Pain Relief

Authorization to Release Medical Records

I hereby authorize The Alaska Center for Pain Relief, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient name: _____

Address: _____

Date of birth: _____ Medical record #:_____

Date(s) of treatment: _____

Release information to: (Name of individual or organization)_____

_____

Address: _____

INFORMATION TO BE RELEASED OR ACCESSED:

___Office Clinical Notes ___ Procedure Notes ___Lab/ Path Reports

___ X-Ray/MRI/CT Reports ___ Billing ___ Other:_____

___ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

*requires special consent

INFORMATION IS NEEDED FOR:

___ Continuing medical treatment ___ Litigation for review ___ Personal use

___Insurance (company name): _____

___ Other (specify reason): _____

3851 Piper St. - Suite U464, Anchorage, AK 99508
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I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The Authorization will expire six(6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature: _____

Patient or Legal Authorized Representative

_____

Printed Name of Patient or Legal Authorized Representative

_____

Relation to Patient

A request may take several working days to process. If there are questions, please contact Alaska Center for Pain Relief at 907-339-4800.

Please Note : A copying fee of $25.00 may be charged "for furnishing a second copy of the patient's medical record upon request by the patient".