INTERNAL MEDICINE ASSOCIATES LLC

Authorization to Use and/or Disclose Health Information

(REQUEST FOR RELEASE OF MEDICAL RECORDS)

Patient _____ DOB: _____ Phone: _____

Address: _____

RELEASING TO/FROM Provider Name(s)/Clinic: Internal Medicine Associates	
Address: 2841 DeBarr Rd, Ste 50, Anchorage, AK 99508	
Phone: 907-276-2811	**Fax:** 907-276-2810

RELEASING TO/FROM Provider Name(s)/Clinic:	
Address:	
Phone:	**Fax:**

I authorize disclosure of the following types of health information:

Types of Health Information *If not checked, default is ALL TYPES*	**Date(s) of Service for requested records:** *If left blank, default is ALL DATES*	**For the following purpose(s):** *If not checked, default is CONTINUATION OF CARE*
☐ Office/Provider Notes	_____	☐ Continuation of Care
☐ Laboratory Reports	_____	☐ Personal Request
☐ Pathology and Biopsy Reports	_____	☐ Insurance Claims
☐ Imaging Studies	_____	☐ Legal Request
☐ Billing Statements	_____	☐ Other: _____
☐ Other: _____	_____	

The following items must be initialed to be included in the use or disclosure of other health information:

_____ HIV/HCV/AIDS / SEXUALLY TRANSMITTED related health information and/or records

_____ Mental health information and/or records

_____ Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information): _____

_____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Practice Manager or the Privacy Officer. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand I have a right to obtain a copy of this Authorization, upon requesting. I understand that this form does not supersede any previously signed Release of Information.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

This release is effective for one year after the date of signature or until _____ (date or event).

Patient Signature Date

Printed Name of Legal Representative (if applicable) Relationship of Legal Representative to Individual