



**Authorization to Disclose Medical Records to Anchorage Women's Clinic**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I authorize Anchorage Women's Clinic to request my health information from:

Dr. \_\_\_\_\_ and/or staff of \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please fax the following information to Anchorage Women's Clinic at 907.770.7891**

I authorize the following information to be disclosed:

\_\_\_\_\_ All my medical records

\_\_\_\_\_ Other, Please state part(s) to be released: \_\_\_\_\_

The following items **MUST** be initialed to be included in the use or disclosure of other records:

\_\_\_\_\_ HIV/AIDS related health information and/or records

\_\_\_\_\_ Mental health information and/or records

\_\_\_\_\_ Genetic testing 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.) \_\_\_\_\_

**\_\_\_\_\_ Psychotherapy notes** (If this authorization is for the psychotherapy notes, then it cannot be combined with any other authorizations.)

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 AWC. Unless revoked earlier, this authorization will expire in 180 days from the date of signing below or upon \_\_\_\_\_.

I also understand that if the person or entity receiving this information is not a healthcare 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.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

\_\_\_\_\_  
Signature of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of legal representative (if applicable)

\_\_\_\_\_  
Relationship of Legal Representative to Patient

Request Processed By: \_\_\_\_\_  
Records were Faxed: \_\_\_\_\_ Mailed: \_\_\_\_\_ Collected: \_\_\_\_\_

Date: \_\_\_\_\_  
# of Pages: \_\_\_\_\_