Authorization to Disclose Medical Records from Anchorage Women's Clinic

Patient Name: ____________________________ Date of Birth: ___________ Phone Number: ____________________

I authorize Anchorage Women's Clinic, LLC (AWC) to release all or part of my medical records as indicated and initialed below to the following:

Name: ____
Address:____
Phone: __________________________Fax:____________________

Records are to be _____Faxed _____Mailed _____Collected (Records in excess of 25 pages must be mailed or collected)
(Please initial appropriate box below)
_____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.

Purpose of Disclosure:

- ☐ Consultation/Second Opinion
- ☐ Personal Copy
- ☐ Referral
- ☐ Transferring Care Due to Relocation
- ☐ Insurance Coverage
- ☐ Continuity of Care
- ☐ Legal
- ☐ Other ________________________

Please allow 10 business days for processing.

____ ________________________
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: _________________________ Date:_______________ Records were____________ # of Pages ___________