AWC
Anchorage Women's Clinic
You take care of everyone else, let us take care of you

Release of Information TO Anchorage Women's Clinic

Patient Name:________________________________ **Date of Birth**:___________ **Phone Number**:______________________

Previous Name:______________________________________ Last 4 Digits of Social Security #:____________________________

I authorize Anchorage Women's Clinic, LLC (AWC), to request my health information from:

(If applicable, please include name of physician AND name of the practice.)

Dr:____ **Practice Name:**____

Address:____

Phone:____ **Fax:**____

I authorize Anchorage Women's Clinic, LLC (AWC), to request the following information:

- ☐ **Labs / Pathology**
- ☐ **Imaging Reports**
- ☐ **Surgical Reports**
- ☐ **OB Records**
- ☐ **Medication List**
- ☐ **Office Visits**
- ☐ **Immunizations**
- ☐ **All Records**

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

________**Genetic testing information and/or records**

________**HIV / AIDS related health information and/or records**

________**Mental health testing 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 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

FOR INTERNAL USE ONLY

Received by:______________________________

Date: ____________________________________

Faxed on: ________________________________

Date records received:______________________

Processed by:_____________________________

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