

3500 LaTouche Street, Suite 240A | Anchorage, AK 99508 | Phone (907) 276-4611 | FAX (907) 258-5167

## **CONSENT FOR RELEASE OF MEDICAL INFORMATION**

Lauthorize my records to be released FROM:  Name	Patient Name:		Date of Birth:	
Name	Lauthorize my records to	be released <b>FROM</b> :		
Address Phone Fax  Reason for disclosure: [] At the request of the individual [] Continuity of Care [] Other, please specify:	•			
Reason for disclosure: [] At the request of the individual [] Continuity of Care [] Other, please specify:  Lauthorize my medical records to be released TO:  Name  Address Phone Fax  Lauthorize the release of the following portions of my medical records: (please initial each authorized catego Mental Health Substance Abuse Imaging Reports Office Note Labs Complete copy of file Other  Records to be released from the following time period: through  Lunderstand that this information shall be in effect for 180 days following the date of signature. However, I understand that this authorization may be revoked at any time by giving written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies. I hereby release Fireweed Health Care, from any and all liability which may arise as a result of my authorized release of records. Should my case require review by a governing				
Lauthorize my medical records to be released TO:   Name				
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submitted to the agency or medical professional for this review. This information has been disclosed to you from records protected by Federal confidentiality rules. For all records requests involving protected records (42 CFR part 2): The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]	shall constitute a valid authorize retrieve them and has no control and all liability which may arise agency or another medical prosubmitted to the agency or me protected by Federal confident rules prohibit you from making written consent of the person to release of medical or other informations.	ration. I understand that once my more of over the use of the already release as a result of my authorized release fessional actively involved in my cardical professional for this review. The ciality rules. For all records requests any further disclosure of this information whom it pertains or as otherwise primation is NOT sufficient for this pure.	edical records have been release sed copies. I hereby release Fire e of records. Should my case rece, it is with my consent that a coais information has been disclose involving protected records (42) mation unless further disclosure permitted by 42 CFR part 2. A garpose. The Federal rules restricted	ed, the medical office cannot weed Health Care, from any juire review by a governing opy of these records will be ed to you from records at the cord to you from records at the cord is expressly permitted by the eneral authorization for the tany use of the information
Patient (or legal representative in lieu of the patient)	Patient (or legal representative	in lieu of the patient)		
Relationship to Patient: Date:	Relationship to Patient:_		Dat	e:
Witness: Date:	Witness:		Date:	