Independence Park Medical Services, Inc.

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(907) 522-1341 Fax (907) 522-1343

Authorization to use and/or disclose health information

Patient Name (Please Print)_____
Date of Birth_____ **Other Names**_____ **SS#**_____
I am the ____Patient ____Guardian ____Other (Please name_____) I authorize Records **FROM**:_____

_____

to use and/or disclose my health information as identified below **TO**:
(Physician Name, Address & Phone Number)

_____

_____

_____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

____ALL MEDICAL RECORDS
____Most recent five-year history
____Chart notes ALL or from _____to _____
____Labs ALL or from _____ to _____
____X-ray/ultrasound ALL or from _____to _____
____Billing statements
____Other (please list)_____

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

____*HIV/AIDS 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 & what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) _____

_____

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert date or event of expiration)_____.

Except to the extent that action has already been taken in reliance upon the authorization, I understand that I may revoke this authorization at any time by giving written notice to Suzi C. (Privacy officer).

I 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 redisclosed and no longer protected by these regulations.

****** IMPORTANT NOTICE******

Patients may receive the first copy of medical records free, excluding charts in storage. Copies of medical records up to 15 double-sided pages will be assessed a fee of $35.00. Copies over 15 pages will be assessed a fee of $35.00 plus $.25 per double sided page. Charts in storage will cost $10.00 plus charges to copy. Payment is required before copies are sent out.

Please allow 10 working 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

Picture ID #_____ **Employee Initials** _____