Independence Park Medical Services

CONSENT TO RELEASE OF INFORMATION

9500 Independence Drive, Suite 900, Anchorage, Alaska 99507
Phone (907) 522-1341 Fax (907) 522-1343
Email address: ipms@ipmsak.net web address: www.ipmsak.com

Patient Name (please print) _____

Date of Birth _____ **Other Names** _____ **SS#**_____

I am the ___ Patient ___ Guardian ___ other, please name _____

By signing this form, I am allowing IPMS to [obtain and/or release] medical information concerning the above named Patient to the person or facility listed below.

_____ _____
Name of Person and or Institution Fax Number

_____
Complete Mailing Address City, State, Zip Code

Check information to be released:

- ☐ All Medical Records ☐ Only recent five-year history ☐ Shot Record
- ☐ Chart notes ALL or from _____ to _____
- ☐ Labs ALL or from _____ to _____
- ☐ X-ray/ultrasound reports ALL or from _____ to _____
- ☐ Billing statements ☐ Other (please list) _____

If you need a copy of an X-Ray contact our Radiology department at 365-5245!

****PLEASE INITIAL, the items below, for such info to be included in the use or disclosure of other health information:**
Federal law prohibits the re-disclosure of such information, only with authorization:

Must Be Completed

____**HIV/AIDS related health information and/or records
____**Mental health information and/or records
____**Drug/alcohol diagnosis, treatment, and/or referral information

Please check the reason for release below; and provide a date which the info is needed by: _____

Moving out of area____ Rehab/disability____ Insurance____ 2nd Opinion____
Personal File____ Legal____ Other medical care____ Transferring Care____

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 I may revoke this authorization at any time by written notice to Suzi, C., Privacy Officer.

******* 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. Copies over 15 pages will be assessed a fee of $35 plus $.25 per double sided page. Charts in storage will cost $10 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

Type of Picture ID verified _____ Employee Initials _____
Patient Received _____ Date _____ *Rev. 2/2016*