



**ORTHOPEDIC PHYSICIANS**  
ALASKA

A Division of OrthoAlaska

3801 Lake Otis Pkwy, Suite 300  
Anchorage, AK 99508  
Ph# (907) 562-2277 Fax# (907) 563-3460

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize: (Who is releasing the records)  Orthopedic Physicians Alaska And/Or  Other \_\_\_\_\_  
to Release Protected Health Information to (Where are the records going):

Myself **or**  O.P.A. **or**  Other \_\_\_\_\_

at Fax# \_\_\_\_\_ **or** Regular U.S. Mail address \_\_\_\_\_

**or** E-mail \_\_\_\_\_ **or**  Person will pick up

Date Needed By: \_\_\_\_\_

|                          | Description:                                          |                          | Date Range: _____ to _____     |
|--------------------------|-------------------------------------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | Entire medical records, Including CD images.          | <input type="checkbox"/> | Emergency Department Report(s) |
| <input type="checkbox"/> | Entire medical records <b>NOT</b> Including CD images | <input type="checkbox"/> | Operative Report(s)            |
| <input type="checkbox"/> | Chart Note(s)                                         | <input type="checkbox"/> | Laboratory Test(s)             |
| <input type="checkbox"/> | Radiology Report(s)                                   | <input type="checkbox"/> | Billing Record                 |
| <input type="checkbox"/> | Radiology CD Imaging                                  | <input type="checkbox"/> | Other: _____                   |

This consent for release of **Protected Health Information** is good for **1 year** unless otherwise stated. **Date Expires:** \_\_\_\_\_.  
I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent and in the manner indicated and authorized herein.

**I acknowledge** that the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse. **YOU MUST INITIAL HERE:** \_\_\_\_\_ **IF YOU DO NOT WANT THIS INFORMATION RELEASED.**

I understand that I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. If the requester or receiver is not a health plan or a health care provider, the released information may not be covered by Federal Privacy regulations; the information described above may be re-disclosed and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

**I further understand and agree that if I direct OPA to mail my records to me or another provider, the records will be mailed regular U.S. Mail.**

\_\_\_\_\_  
Signature of Patient or Patient's legal guardian

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date:

**For administrative use only-**

Date Completed: \_\_\_\_\_

Completed by: \_\_\_\_\_

Records Were:  Mailed  Picked up  Faxed  Emailed

Faxed to# (If different from above): \_\_\_\_\_

CD Imaging:  Mailed  Picked up  Pushed

**Completed Form to Be Filed in Patient's Record**