ORTHOPEDIC PHYSICIANS ALASKA
OrthoAlaska LLC

Release of Information Authorization

3801 Lake Otis Parkway, Suite 300
Anchorage, AK 99508

Ph: (907) 562-2277
Fax: (907) 563-3460

Patient Name: _____
Date of Birth: _____

I authorize Orthopedic Physicians Alaska a Division of OrthoAlaska or [_____ at Fax Number: _____] to Release Protected Health Information to:

Name: _____ Address: _____

Phone Number: _____ Fax Number: _____

Date Needed by: _____ Patient to Pick Up: YES NO

	Description:	Date(s):		Description:	Date(s):
□	**Entire medical record,** including CD images**.**		□	Emergency Department Report(s)	
□	**Entire medical record,** NOT including CD images.		□	Operative Report(s)	
□	Chart Note(s)		□	Laboratory Test(s)	
□	Radiology Report(s)		□	Billing Record	
□	Radiology CD Images		□	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 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.

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

_____ _____

Witness **Date**

For administrative use only

Date Completed: _____ **Completed by:** _____

Records were: □ **Mailed** □ **Picked Up** **Faxed to #:** _____

Completed Form to Be Filed in Patient's Record