DIMOND MEDICAL CLINIC 300 East Dimond Blvd. Anchorage, AK 99515 Phone: 341-7757 Fax: 341-7760	**ALASKA MEDICAL CLINICS, LLC** 	**WASILLA MEDICAL CLINIC** 1700 E. Parks Hwy. #200 Wasilla, Alaska 99654 Phone: 373-6055 Fax: 373-6077

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

PATIENT:	Date of Birth
Name of Patient/Previous Names	Birth Date/Medical Record Number
Street Address	Social Security No.:
City, State, Zip	I am the: ☐ Patient ☐ Parent ☐ Guardian ☐ Designee

AUTHORIZES (RELEASE OF MEDICAL INFORMATION FROM):	**RELEASE OF PROTECTED MEDICAL INFORMATION TO:**
Name of Health Care Provider/Plan/Other (check one): ☐ Wasilla Medical Clinic ☐ Dimond Medical Clinic ☐ Other (specify): ______________________	Name of Health Care Provider/Plan/Other (check one): ☐ Wasilla Medical Clinic ☐ Dimond Medical Clinic ☐ Other (specify): ______________________
Street Address	Street Address
City, State, Zip	City, State, Zip

INFORMATION TO BE RELEASED:

☐ Medical History	☐ Laboratory Reports
☐ Treatment or Tests	☐ Entire Record
☐ Consultations	☐ Immunizations
☐ Surgical Reports	☐ X-Rays or X-Ray Report
☐ History and Physical	☐ Prescriptions
☐ ER Reports	☐ Other (Specify):____________________________

For the following dates: From ________________ to ________________________________

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

☐ Further Medical Care	☐ Legal Investigation or Action
☐ Insurance Eligibility/Benefits/Claims	☐ Changing Physicians
☐ Workers Compensation	☐ Personal
	☐ Other (Specify):______________________________

HIPPA PRIVACY RULE: CONSENT, INFORMATION DISCLOSURE,AND AUTHORIZATION

All information provided by the patient is deemed private under the Health Insurance Portability and Accountability Act (HIPPA) and will be used only with patient consent. I hereby authorize Alaska Medical Clinics, LLC, dba Wasilla Medical Clinic and Dimond Medical Clinic, to furnish information to other providers or healthcare or treatment facilities.

I acknowledge that the information to be released may include material that is protected by federal law. My initials and signature below authorize release of the following type of information:

_______ Drug/Alcohol Abuse _______ Mental Health _______ HIV/AIDS

______________________________ ______________________________

Signature of Patient/Legal Representative Signature of Witness

______________________________ ______________________________

Date Date