



Alaska Medical Clinics, LLC
 Alaska Urgent Care
 300 E Dimond Blvd, #12A
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Previous Name (if any): _____

Date of Birth: _____ SS#: _____ Phone #: _____

I give authorization for the use or disclosure of the above individual's health information as described below:

- 1) **Released From:** _____ Alaska Urgent Care _____ Other

Facility Name: _____

Address: _____ State _____ Zip _____

Phone #: _____ Fax: _____

- Released to:** _____ Alaska Urgent Care _____ Other

Facility Name: _____

Address: _____ State _____ Zip _____

Phone #: _____ Fax: _____

- 2) Type of information to be used or disclosed (check all that apply)

____ All Medical Record Types ____ History & Physical ____ Chart Notes

____ Lab Results ____ Radiology Reports

____ Other (specify): _____

- 3) I acknowledge that the information to be released **may include** material that is protected by the Federal Law and includes any of the following specific confidential information (initial all that may apply):

4) _____ HIV/AIDS _____ Reportable STDs _____ Mental Health _____ Substance Abuse

- 5) Dates of Service requested (check one):

____ All Medical Records

____ Past 12 months

____ The specific period from _____ to _____

This authorization expires on _____, or 90 days from the date of signature. I understand that I have the right to revoke this consent any time in writing except to the extent that the information has already been released.

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 Alaska Urgent Care, LLC to further information to other providers, healthcare, or treatment facilities.

 Patient or Legal Guardian Signature

 Date