Alaska Medical Clinics, LLC
Wasilla Medical Clinic
1700 E. Parks Hwy., #200
Wasilla, AK 99654
Phone: 907-373-6055 | Fax: 907-373-6071

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: _____ Wasilla Medical Clinic _____** Other
   Facility Name: _____
   Address: _____ State_____ Zip_____
   Phone #: _____ Fax: _____

   Released to: _____ Wasilla Medical Clinic _____ 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):

   _____HIV/AIDS _____Reportable STDs _____Mental Health _____ Substance Abuse

4) 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 Wasilla Medical Clinic, LLC to further information to other providers, healthcare, or treatment facilities.

_____ _____
Patient or Legal Guardian Signature Date