Alaska Hand-Elbow-Shoulder
Alaska's Premier Upper Extremity Surgical Specialists
4015 Lake Otis Parkway, Suite 201 Anchorage, AK 99508 | (907) 771-3500 | www.akhanddoc.com

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Patient Name: _____ **D.O.B.:** _____ **SSN:** _____

I authorize _____

_____

(Name, Address, Phone & Fax # of Provider you are requesting records from)

To disclose my health information as identified below to: **Alaska Hand-Elbow-Shoulder**
4015 Lake Otis Pkwy, Ste 201
Anchorage, AK 99508
(907) 771-3500 ; Fax (907) 771-3550

By ***initialing*** the spaces below, I specifically authorize the use or disclose of the following health information and/or records, if such information and/or records exists:

☐ Please send the entire medical record (all information) to the above name recipient.

OR

☐ All hospital records (including nursing records & progress notes.)
☐ Operative reports
☐ Medical records needed for continuity of care
☐ Most recent five-year history
☐ Emergency and urgent care records
☐ Office chart notes
☐ Laboratory reports
☐ Pathology reports
☐ Diagnostic imaging/X-Ray reports
☐ Billing statements/Full account ledger

Other: _____

*The following items must be initialed to be included in the use or disclosure of other health information.

☐ *HIV/AIDS related health information and/or records
☐ *Mental health information and/or records
☐ *Genetic testing information and/or records
☐ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

☐ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Medical Records Department at AkHES office. Unless revoked earlier, this authorization will be expire **180 days** from the date of signing or _____

(Expiration Date)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any of information to be used or disclosed under this authorization. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no long protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____

***Signature of individual or individual's legal representative** **Date**

**By typing your name in this area you are stating that above information is true and correct to the best of your knowledge and this electronic form of signature will be treated the same as your original signature.*

_____ _____

Print Name of Legal Representative (if applicable) **Relationship to Individual**

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)