Providence | Alaska Medical Center

3200 PROVIDENCE DRIVE
P.O. BOX 196604
ANCHORAGE, ALASKA
99519-6604

Tel 907 562-2211

RELEASE OF MEDICAL INFORMATION

Patient Name:______________________ Birthdate: ______________
Social Security #: ____________________ Treatment Date(s):__________

I Authorize **PROVIDENCE ALASKA MEDICAL CENTER**, PO Box 196604, Anchorage, AK 99519 to release the following medical information to the party listed below.

Release to: ____
Mail:______ Fax:______ Pick-up:______ Fax #:( ) ______________
Address:______________________________ Contact #:______________
______________________________ When Needed:____________

Information requested to be released:

____History and Physical
____Discharge Summary
____Laboratory Reports
____Radiology Reports
____Radiology Films
____Clinic Reports
____Emergency Reports
____Consultation
____Pathology Reports
____Other (Please List)
____
____

For the purpose of:

____Further Treatment
____Insurance Claims
____Workers Compensation
____Legal Request
____Personal Records
____Other (Please List)
____
____

I acknowledge that the data to be released <u>MAY INCLUDE</u> material that is protected by Federal Law. My initials and my signature below authorize release of the following type of information.

__Drug/Alcohol Abuse Information __Mental Health __HIV Information

This consent is specifically for information created from services provided before the date of my signature. Information related to services provided after the date of my signature will require an updated authorization. In addition, this consent is subject to revocation at anytime except to the extent that the department that is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: ______________(date). Not to exceed 90 days.

Printed Name:__________________________ Signature:____________________
Relationship to Patient:____________________ Date:__________________
Witness:______________________________ Date:__________________

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# of Pages Copied: ________ Charges:$________ Completed by:____________
Date Completed:______________ MR#:____________________

PAMC 8691-20 (2/98)