Generations Medical Center
3505 E. Meridian Park Lp Suite 100
(907) 357-4963 Fax (907) 357-1894

Authorization for Disclosure of
Protected Health Information
HIPPA Compliant

Patient Name: ____ DOB: _______________ SSN: _________________________
Address: ____ City: ________________ St/Zip: ________________________

I Request Information From:

Generations Medical Center
3505 E. Meridian Park Lp Ste 100
Wasilla, AK 99654 Fax: 907-357-1894

To Be Disclosed To:

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Disclosure Method: ☐ Fax to:_____________________ ☐ E-mail to address on file ☐ USPS Mail ☐ In Person Pickup

I authorize the following information to be released from my record(s) to include these dates of service:

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☐ History & Physical ☐ Annual Exam ☐ Progress Notes ☐ Hospital In & Outpatient Records
☐ Consult Reports ☐ Pathology Reports ☐ Lab Reports ☐ Radiology/Imaging Reports
☐ Billing Records ☐ Other (Specify) ____

Some medical records may contain extremely confidential information. I DO consent to the release of the following information relating to (if left blank, authorization to release information is NOT assumed):

☐ Genetic testing and results_________ (Initials) ☐ Mental Health Conditions ____________(Initials)
☐ HIV/AIDS testing and results __________(Initials) ☐ Drug or Alcohol abuse treatment _________ (Initials)

Information listed above will be disclosed for the following purpose: ____

Potential for Re-disclosure: Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.
Rights of the Individual: You may inspect or request a copy of the information that is used or disclosed under this authorization. You may refuse to sign this authorization.
Effects of Refusing Authorization: If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for the purpose of treatment, payment, or supporting the operation. If you refuse to sign this authorization, you may not be eligible for or receive research-related treatment that you have requested for the purpose of disclosure to others.
I also understand this consent/authorization may be revoked at any time except to the extent already acted upon. Revocation must be made in writing and presented or mailed to Generations Medical Center. Unless otherwise indicated this consent will expire in one (1) year from the date signed. I understand that records requested for traveling OB patients are free and all records requested for personal use will be charged a copy fee of $1 per page for the first 25 pages and $0.25 for each additional page.

Patient Signature: ____ **Date:** ________________ **Expires:** __________________
Authorization Representative: ____________________________ **Relationship:** ________________ **Date:** _____________
(If other than patient)

OFFICE USE ONLY: MR # ______________________
1. Identification: ☐ Driver's License Viewed State ________ # ____________________ ☐ Other ____________________
2. Person authorized by the patient, do they have:
   ☐ Power of Attorney for Health Care ☐ Legal Guardianship Papers (make copy of any related paperwork)
3. ☐ Patient requests records to be copied to USB drive. Charge: $40.00

Received By: ___________________# of pages ________ Date: _____________ Time: _____________
Released By: __________________________________ Date: ______________________ Time: ______________________
Of Pages: _____________ (Completed by person copying records) Charge: ___________________________