

Generations Medical Center
3505 E. Meridian Park Lp, Ste. 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:

To Be Disclosed To:
Generations Medical Center
3505 E. Meridian Park Loop, Suite 100
Wasilla, AK 99654 Fax 907-357-1894

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Annual Exam | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Hospital In & Outpatient Records |
| <input type="checkbox"/> Consult Reports | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology/Imaging Reports |
| <input type="checkbox"/> Billing Records | <input type="checkbox"/> 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):

- | | |
|--|---|
| <input type="checkbox"/> Genetic testing and results _____ (Initials) | <input type="checkbox"/> Mental Health Conditions _____ (Initials) |
| <input type="checkbox"/> HIV/AIDS testing and results _____ (Initials) | <input type="checkbox"/> 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 the releasing entity. Unless otherwise indicated this authorization will expire one (1) year from the date signed.

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)

Received By: _____ # of pages _____ Date: _____ Time: _____

Released By: _____ Date: _____ Time: _____

Of Pages: _____ (Completed by person copying records) Charge: _____