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:

____

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

Records containing the following extremely confidential information will NOT be released unless additional authorization is given by initialing next to the section. I DO consent to the release of the following information relating to:

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 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 _________ Employee Initials ______
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: ____________