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RELEASE OF MEDICAL INFORMATION

I, _____ (patient), authorize (name) _____

(address/fax) _____ (phone) _____

To disclose my protected health information to (name) _____

(address/fax) _____ (phone) _____ for the purpose of:

☐Treatment ☐Coordination of Care ☐Payment of Services
☐Other: _____

The information that may be released is as follows:

☐History & Physical
☐Lab Reports
☐Treatment Record
☐Medication Record
☐Hospital Reports
☐Progress Notes
☐Radiology Reports/Images
☐Pathology Reports
☐Operative Reports
☐All Records in relation to: _____
(diagnosis, symptom, illness, injury)
☐Other: _____

This release of information will expire on _____ or one year after date of signature, whichever is first.

I understand that I may revoke this authorization at any time by submitting a written request to Practice Manager at Alaska Shoulder and Orthopaedic Institute.

I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment.

_____ _____
Patient's Signature Date

_____
Guardian Signature