

Providence Imaging Center
3340 Providence Drive
Anchorage, AK 99508

Tel. 907-212-3151 Fax 907-212-3119



1RELE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Notice: This request is not valid unless all requested information is provided.

Release From: Name: **Providence Imaging Center** Phone: **907-212-3151**
Address: **3340 Providence Drive, Anchorage, AK 99508**

Release To: Name: **self / patient** Phone: _____
Address: _____

Patient Identification:

Patient Name: _____ Date of Birth: _____

Address: _____ Social Security #: _____

Telephone #: _____

Information To Be Released (Please be specific):

From (date) _____ To (date) _____ Or information pertaining to: _____

Please check type of information to be released:

- | | | |
|--|---|---|
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Medication Sheets | <input type="checkbox"/> Psychiatric Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Diagnosis/Procedure Note | <input type="checkbox"/> Complete Medical Record |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes | <input checked="" type="checkbox"/> X-ray Films/Images/CD's |
| <input type="checkbox"/> Laboratory/Pathology Test Results | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Photographs/Videotapes/CD's |
| <input type="checkbox"/> Emergency Dept. Reports | <input type="checkbox"/> Assessments/Evaluations | <input type="checkbox"/> Itemized Bill |
| <input type="checkbox"/> Other, (specify) _____ | | |

Receive by: Mail Pick-up

Purpose of the Request:

Personal (at the request of the patient) Treatment Legal Insurance Government

Other, (specify) _____

Terms

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following **date or event:** _____

Re-disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____

8691-070 (Rev. 6/06)



Providence Health System

Alaska Region

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