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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: _____ Phone: _____

Address: _____

Release To: Name: **Providence Imaging Center** Phone: **907-212-3151**

Address: **3340 Providence Drive, Anchorage, AK 99508**

Patient Identification:

Patient Name: _____ Date of Birth: _____

Address: _____

_____ Telephone #: _____

Information To Be Released (Please be specific):

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

Please check type of information to be released:

☐ History & Physical Exam	☐ Medication Sheets	☐ Psychiatric Reports
☐ Discharge Summary	☐ Diagnosis/Procedure Note	☐ Complete Medical Record
☐ Consultation Reports	☐ Progress Notes	☐ X-ray Films/Images/CD's
☐ Laboratory/Pathology Test Results	☐ X-ray Reports	☐ Photographs/Videotapes/CD's
☐ Emergency Dept. Reports	☐ Assessments/Evaluations	☐ Itemized Bill

☐ Other, (specify) _____

Receive by: ☒ Mail ☐ Pick-up

Purpose of the Request:

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

☒ Other, (specify) **continued care**

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)

PLACE PATIENT
ID LABEL HERE

Providence | Health System
Alaska Region

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