CARING FOR WOMEN, PC
2841 DeBarr Road, Suite 37
Anchorage, Alaska 99508
Phone: (907) 279-2229 / FAX (907) 279-3817

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth ____/____/____
(Please Print)

Please Release a Copy of my Medical Records:
From ☐/ To ☐

From ☐/ To ☐
Caring For Women
2841 DeBarr Road, Suite 37
Anchorage, Alaska 99508

_____
_____
_____

For the following purpose(s):

____ Further Treatment
____ Second Opinion
____ Transferring Care
____ Other (Specify) _____
_____

Enclose

____ Chart Notes
____ Lab Results
____ Pap/Pathology
____ Radiology

The following items must be initialed to be included in the Use or Disclosure of Protected Health Information:

____ HIV/AIDS
____ Mental Health
____ Genetic Testing
____ Drug/Alcohol Diagnosis, treatment, referral
____ Sexually Transmitted Diseases

____ Physician may exchange information by phone, fax or other means necessary for treatment with:
(Physician/Provider's Name): _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Caring For Women, PC. Unless revoked earlier, this authorization will expire 180 days from the date of signing this authorization.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain Treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receiver compensation (either directly or indirectly) for doing so.

_____ Date
Patient Signature

_____ Relationship to Patient
Signature of Person Authorized to Sign for Patient

_____
Print Name of Authorized Signor

_____ Date
Provider's Signature

_____ Date
Authorized Employee

_____ Home Phone Number
Current Mailing Address

_____ Work/Message Phone Number

NOTICE: COPIES OF ALL MEDICAL RECORDS WILL BE HELD IN THIS OFFICE FOR A MAXIMUM OF 90 DAYS AND A FEE WILL BE ACCESSED FOR ANY RECOPIES

Revised 9/05