Alaska Trauma & Acute Care Surgery, LLC
3220 Providence Drive, Suite E3080
Anchorage, Alaska 99508-6907
Ph: 907.375.8785
Fax: 907.375.8788

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: ____

Date of Birth: ___________________ Contact Phone number: ____________________

I REQUEST AND AUTHORIZE: Alaska Trauma & Acute Care Surgery, LLC to process the following request in regards to my medical records:

□ OBTAIN □ SEND

My medical records: □ from □ to the following Provider:

Name: ____
Address: ____
City: __________________________________State: ________ Zip: ___________
Phone*: ___________________ Fax: _____________
*information REQUIRED to complete request!!!

I AUTHORIZE the following information to be disclosed: (Please check all that apply)

- □ Entire Chart
- □ X-Rays
- □ Billing Records
- □ Other: ____

Additional Information:
____

This authorization expires on ________ or, 90 days from the date of signature. I understand I have the right to revoke this consent at any time in writing except to the extent that the information has already been released.

_________________________________ _____________________
Signature Date

*Section 164.506 © (1) of the HIPAA Privacy Regulation states a covered entity is not required to obtain a patient authorization to use or disclose patient health information for treatment, payment, or its own health care operations.

HIV ONLY: I understand specific reference may be made to HIV testing and results, and any related diagnosis and medical condition(s) which may be recorded in my health records. I hereby authorize the release of any HIV antibody test results and related information. Exchange of information ensures continuity of care between providers. By not sharing information my heath care could be compromised. Only that information which I authorize will be released.

_________________________________ _____________________
Signature Date