ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

3831 Piper Street Suite S450 Anchorage, Alaska 99508 Phone 907-258-6999 Fax 907-258-6247

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This authorization affects your rights in the privacy of your Protected Health Information. Please read it carefully before signing.

Patient Name:_____
Date of Birth:_____ SSN: _____
Address:_____ Phone:_____
_____ Fax:_____

I authorize Anchorage Neurosurgical Associates, Inc., to
☐ **disclose my health care information to:** ☐ **obtain my health care information from:**

Name: _____
Organization: _____
Address: _____
_____
_____
City, State, Zip code: _____
Phone (include area code): (_____)_____ Fax: (_____)_____

Release the following information:
☐ Progress Notes/Treatment Plan ☐ Op Report(s) ☐ Consultation(s)
☐ X-ray/Radiology Report(s) ☐ Laboratory/Pathology Report(s) ☐ Itemized Billing
☐ Other: _____ ☐ Entire Medical Record

**Note: You are hereby authorizing disclosure of all information in the items you have checked above, including information from previous providers and information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease contained in the items checked above.*

Reason for this Request:
☐ At my request ☐ Other: _____

Expiration Date of Request: This authorization will remain in effect for one (1) year, unless I have checked or filled in a different expiration date. ☐ None ☐ Other: _____

I understand that:
- After the custodian of records discloses my Protected Health Information, it may no longer be protected by federal privacy laws.
- I further understand that this Authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
- I have the right to revoke this authorization in writing at any time.

By signing below I represent and warrant that I have authority to sign this document and to authorize the use or disclosure of Protected Health Information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this Protected Health Information.

_____ Date: _____
Signature of Patient or Legal Representative

_____
If signed by Legal Representative, relationship to patient

FOR OFFICE USE ONLY

INTAKE BY: _____ PROCESSED BY: _____

RECORDS WERE: ☐ MAILED ☐ FAXED