Hillside Family Medicine, LLC
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Patient Name: _____ **Date of Birth**: _____

Release of Personal Health Information Family and Friends

I authorize Hillside Family Medicine to release my personal health information, "PHI", to the following:

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

By signing below, you agree that Hillside Family Medicine may release "PHI" to the above individual(s). This release will remain in effect until _____. If no date is entered this release will remain in effect for one year from the date signed below.

This release does not give permission to the delegated person(s) to …..

1. Ask for a complete copy of your medical records, a signed Release of Information is required.
2. Have access to any medical records that have been noted as confidential.
3. Pick-up prescriptions for controlled medications, verbal permission must be given each time a prescription is to be picked up by someone other than yourself and must be documented in your chart.

If you wish to cancel this release you must do so in writing directed to:

Front Desk Staff
Hillside Family Medicine
9220 Lake Otis Pkwy, Ste 9
Anchorage, AK 99507

If you have any additional questions please call (907) 344-0200 option 1, for the Front Desk Staff.

Signature: _____ Date: _____