

# 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:** \_\_\_\_\_