Hillside Family Medicine, LLC

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AUTHORIZATION TO RELEASE INFORMATION*

Patient Name: _____ Date of Birth: _____

Contact Phone number: _____

I request and authorize:

Hillside Family Medicine, LLC 9220 Lake Otis Pkwy, Suite 9 Anchorage, Alaska 99507 Phone: (907)344-0200 Fax: (907) 344-0214 Records Requested by:_____	**To Receive Medical Records From**	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone*: _____ Fax: _____ **information **REQUIRED** to complete request!!!*
Hillside Family Medicine, LLC 9220 Lake Otis Pkwy, Suite 9 Anchorage, Alaska 99507 Phone: (907)344-0200 Fax: (907) 344-0214	**To Send Medical Records To**	Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone*: _____ Fax: _____ **information **REQUIRED** to complete request!!!*

Records are to be _____Faxed _____Mailed _____Collected

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 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