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