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Anchorage, AK 99503
P: (907) 677-9200
F: (855) 652-6201

Release of Information Authorization Form

Patient Name: _____ Date of Birth:_____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

I hereby authorize AMS to **obtain** my medical records from _____

I hereby authorize AMS to **release** my medical records to: [ ] Myself [ ] Other: _____

How Should Information Be Released? (check all that apply):

☐ **In-Person Pickup**
☐ **Email** – Email Address: _____
☐ **Fax** – Fax Number: _____
☐ **Mail** – Address: _____
☐ **Other**: _____

Purpose of Disclosure:

☐ Continuity of Care
☐ Legal
☐ Insurance
☐ Personal
☐ Other: _____

Information to Be Released (check all that apply):

☐ Complete Medical Record
☐ Chart Notes: All / From _____ To _____
☐ Lab Reports: All / From _____ To _____
☐ Radiology: All / From _____ To _____
☐ Other (please specify): _____

The following items must be initials to be include in the medical record request:

_____ HIV/AIDS related to health information
_____ Mental Health information
_____ Drug/alcohol diagnosis, treatment, and/or referral information

Authorization Expiration

This authorization will expire 365 days from the date signed or on this date: _____

Patient Rights & Acknowledgments

- I understand that I may revoke this authorization at any time by providing written notice..
- I understand that any revocation will not apply to information already released in reliance on this authorization.
- I understand that my treatment or payment cannot be conditioned on the signing of this authorization.
- I understand that once information is released pursuant to this authorization, it may no longer be protected under HIPAA privacy regulations.

Patient or Legal Representative Signature: _____ Date: _____