AUTHORIZATION TO RELEASE OF CONFIDENTIAL INFORMATION

Patient's Full Name: _____ **Date of Birth:** _____

Former Name(s) _____

I authorize CENTRAL PENINSULA INTERNAL MEDICINE to release information to:

Name _____ **Phone#** _____

Address _____ **Fax#** _____

I authorize _____

To release my medical information to CENTRAL PENINSULA INTERNAL MEDICINE ASSOCIATES

☐ by FAX 844-912-3956 ☐ by mail 247 N Fireweed St Suite A, Soldotna, AK 99669

Information to be released:

- ☐ Most recent 2 years
- ☐ Problem List/Medications
- ☐ X-Ray Reports
- ☐ Other (list)
- ☐ All Medical Records
- ☐ Chart Notes
- ☐ Laboratory Reports

For the purpose of:

- ☐ Further medical treatment
- ☐ Payment of claim
- ☐ Legal Request
- ☐ Personal

Date(s) of Service: _____

I acknowledge that the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the Central Peninsula Internal Medicine Associates. I understand that the revocation will not apply to information that has already been released in response to this authorization, and that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In absence of a revocation, this specific authorization expires on _____ (if left blank, will expire 90 days from date of my signature). Maximum for authorization is 1 year from date of signature.

I understand that once the above information is disclosed, it may be re-disclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

_____ _____ _____

Patient or representative signature **Date** **Witness**

FOR OFFICE USE ONLY

PAGES _____ FEE $ _____ PROCESSED BY _____ DATE _____

RECORDS WERE ☐ MAILED ☐ PICKED-UP ☐ COURIER ☐ FAXED to # _____

RECORDS TO BE PICKED UP ON _____ CONTACT PHONE # _____

Receipt for Record Copies ☐ **ID Checked** **Patient Copy of Authorization:** **Given** ____ **Declined** ____

I hereby acknowledge receipt of the above noted medical records _____

Signature Date

COMPLETED FORM TO BE FILED ON PATIENT'S RECORD

central peninsula internal medicine
247 N Fireweed St Suite A
Soldotna, AK 99669
ph 907-714-5730 ~ fax 844-912-3956