HIPAA Privacy Authorization Form
Request for Release of Medical Records

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164

Authorization

Printed name of patient or personal representative and relationship to patient:

_____ Date ____/_____/_____

I authorize _____ (healthcare provider) to release and disclose the protected health information described below to/from:

TO: Glacier Bay Medical and Diabetes Care Center
615 E. 82nd Avenue, Ste. 302
Anchorage, Alaska 99518
P. 907-302-5750
F. 855-556-6673

FROM:_____
_____
_____
_____
_____

Effective Period-This authorization for release of information covers the period of healthcare from:

Dates: ____/_____/_____ to ____/_____/_____ OR _____ ALL dates of service

Extent of Authorization:

I authorize the release of all records listed below (you must initial next to each section you wish to release):

_____CD of all x-ray and scans, reports and film
_____Pathology slides/reports from any biopsies or surgeries
_____All lab reports
_____Doctor's office/hospitalization records/consults
_____Mental health records
_____Drug, alcohol or substance abuse records
_____HIV/AIDS test results
_____STI records/results
_____Genetic testing/counseling

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing, or claims payment, or other purposes as I may direct.
- I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected under federal or state law.

Printed Patient Name:_____ DOB: _____/_____/_____

Signature of patient or personal representative: _____

Phone Number: _____