Avante Medical Center
915 W. Northern Lights
Anchorage, AK 99503

P 907.770.6700
F 907.770.6707

Authorization to Use and Disclose Health Information

Authorization Requesting Health Information FROM Following Entity or Provider:

Provider/Entity:_____

Phone: _____ Fax: _____

Authorization To Disclose Health Information FOR the Following Patient:

Name: _____ DOB: _____Phone: _____

Current Address: _____
City State Zip

Authorization to Disclose Health Information TO the Following Recipient:

Provider/Entity: _____Phone: _____

Current Address: _____
City State Zip

Receive by: ☐ Mail ☐ Pick up ☐Verbal Exchange ☐ Fax #:_____

The Purpose of the Disclosure is: ☐ My Personal Use ☐ Provider Requested

I Hereby Request ☐ To Review ☐ To Copy

For the date range of: _____to _____

Or pertaining to: _____

Health Information needed by : ☐ ASAP/Emergent ☐ Date Needed _____

Please send the information as indicated:

☐ Discharge Summary ☐ Emergency Dept Visit ☐ X ray Films/Images ☐ X Ray Reports

☐ Progress Notes ☐ Psychiatric Reports ☐ Lab Results ☐ Most Recent Visit

☐ Other _____

TERM: I understand this authorization is specifically for information created from services provided before my date of signature. Information related to services provided after my date of signature will require an updated authorization. This authorization will expire (insert date or event): _____. If I fail to specify an expiration date or event, this authorization will expire six months form the date on which is was singed.

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in a writing and present my written revocation to Avante Medical Center. I understand that the revocation will not apply to information that had already been released in response to this authorization.
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclose of the information identified above is voluntary. I need to sign this form to ensure healthcare treatment.
- I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____

SIGNATURE OF PATIENT or LEGAL REPRESENTATIVE DATE