

CARING FOR WOMEN, PC
 2841 DeBarr Road, Suite 37
 Anchorage, Alaska 99508
 Phone: (907) 279-2229 / FAX (907) 279-3817

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth ____/____/____
 (Please Print)

Please Release a Copy of my Medical Records:
 From / To

From / To
 Caring For Women
 2841 DeBarr Road, Suite 37
 Anchorage, Alaska 99508

For the following purpose(s):

Enclose

The following items must be initialed to be included in the Use or Disclosure of Protected Health Information:

- Further Treatment
- Second Opinion
- Transferring Care
- Other (Specify) _____

- Chart Notes
- Lab Results
- Pap/Pathology
- Radiology

- HIV/AIDS
- Mental Health
- Genetic Testing
- Drug/Alcohol Diagnosis, treatment, referral
- Sexually Transmitted Diseases

____ Physician may exchange information by phone, fax or other means necessary for treatment with:
 (Physician/Provider's Name): _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Caring For Women, PC. Unless revoked earlier, this authorization will expire 180 days from the date of signing this authorization.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain Treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the persons(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

 Patient Signature

 Date

 Signature of Person Authorized to Sign for Patient

 Relationship to Patient

 Print Name of Authorized Signor

 Provider's Signature

 Date

 Authorized Employee

 Date

 Current Mailing Address

 Home Phone Number

 Work/Message Phone Number

NOTICE: COPIES OF ALL MEDICAL RECORDS WILL BE HELD IN THIS OFFICE FOR A MAXIMUM OF 90 DAYS AND A FEE WILL BE ACCESSED FOR ANY RECOPIES

Revised 9/05