Frontier Family Medicine
545 N Knik St Ste A, Wasilla Ak 99654
373-3940

RELEASE OF MEDICAL INFORMATION

Patient Full Name: _____

Date of Birth: _____ Social Security: _____

I Request Medical Information:

[ ] From
[ ] To

Name: _____

Address: _____ State/Zip: _____

Phone Number: _____ Fax Number: _____

Dates Seen: _____

I. My Authorization
You may use or disclose the following health care information for my continued care:

□ Complete Records □ Chart Notes □ Imaging Results
□ History & Physical □ Lab Results □ Medication List
□ Other (please specify): _____

_____

Some medical records may contain extremely confidential information. I do consent to the release of the following information relating to (if left blank, authorization to release information is NOT assumed)
Drug or alcohol abuse: _____ (initials)

Mental health conditions: _____ (initials)

HIV testing, infection status or care and treatment for AIDS: _____ (initials)

Please disclose records to: □ **Frontier Family Medicine, LLC Fax: 907-373-3948**
□ **Other:** _____

This consent will expire on _____or 60 days after the date below.

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form: to take part in a research study or to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Lighthouse Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to fill out a revocation form or write a letter to the office. The form is available from the office. You may inspect or request a copy of information that is used or disclosed under this authorization. You may refuse to sign this authorization. Once the office discloses health information, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient, Parent or Guardian's Signature Print Name

_____ _____ _____

Today's Date Relationship to patient Witness

Updated 03/24/21