Providence

Imaging Center

PLACE PATIENT
ID LABEL HERE

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Notice: This request is not valid unless all requested information is provided

Release From:	Name:	Phone:
	Address:	
Release To:	Name: Providence Imaging Center	Phone: 907-212-3151
	Address: 3340 Providence Drive, Suite 101, Anchorage, AK 99508	

Patient Identification:

Patient Name:	Date of Birth:
Address:	Telephone #:

Information To Be Released (Please be specific):

From (date): _____ To (date): _____ Or information pertaining to: _____

Please check type of information to be released:

☐ Consultation Reports
☐ Laboratory / Pathology Test Results
☐ Imaging Reports
☐ Complete Medical Record
☐ CD Images
☐ Other (specify): _____

Receive by:

☐ Mail
☐ Pick-up
☐ E-Mail _____
☐ Fax (Reports only)
☐ Digital Push

Purpose of Request:

☐ Personal (at the request of the patient)
☐ Treatment
☐ Legal
☐ Insurance
☐ Government
☐ Other (specify): _____

Terms

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writting to the Health Information Services Department. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following date or event: _____

Re-disclosure

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____ **Date:** _____

If signed by legal representative, relationship to patient: _____

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