

**Providence Imaging Center**  
**3340 Providence Drive**  
**Anchorage, AK 99508**  
**Tel. 907-212-3151 Fax 907-212-3119**



\*1RELE\*

**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, 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:***

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> History & Physical Exam           | <input type="checkbox"/> Medication Sheets        | <input type="checkbox"/> Psychiatric Reports   |
| <input type="checkbox"/> Discharge Summary                 | <input type="checkbox"/> Diagnosis/Procedure Note | <input type="checkbox"/> Complete Medical Record                                       |
| <input type="checkbox"/> Consultation Reports              | <input type="checkbox"/> Progress Notes           | <input checked="" type="checkbox"/> X-ray Films/Images/CD's ( <b>circle one only</b> ) |
| <input type="checkbox"/> Laboratory/Pathology Test Results | <input checked="" type="checkbox"/> X-ray Reports | <input type="checkbox"/> Photographs/Videotapes/CD's                                   |
| <input type="checkbox"/> Emergency Dept. Reports           | <input type="checkbox"/> Assessments/Evaluations  | <input type="checkbox"/> Itemized Bill   |

Other, (specify) **original mammograms & reports for the past ten years**

**Receive by:**  Mail  Pick-up

**Purpose of the Request:**

- Personal (at the request of the patient)  Treatment  Legal  Insurance  Government

Other, (specify) **continued care**

**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 writing 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:** \_\_\_\_\_

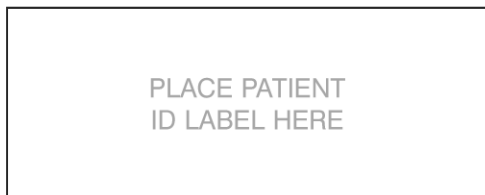
**Re-disclosure**

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:** \_\_\_\_\_

8691-070 (Rev. 6/06)



PLACE PATIENT  
ID LABEL HERE



Providence Health System

Alaska Region

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