Providence Pediatric Subspecialties Clinic
3831 Piper Street Suite S-220 Anchorage, AK 99508
Phone: 907-212-4824 Fax: 907-212-4831

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

This request is not valid unless all requested information is provided.

Patient Information	**Name:** _____ **Date of Birth:** _____ **Address:** _____ **I authorize the release of protected health information for the above-named patient as indicated below:**
RELEASE FROM	**I request patient's information be sent FROM:** ☐ Providence Medical Group Pediatric Subspecialties Clinic 3831 Piper Street Suite S-220 Anchorage, AK 99508 Phone: 907-212-4824 Fax: 907-212-4831 ☐ Name: _____ Phone: _____ Address: _____ Fax: _____
RELEASE TO	**I request patient's information be sent TO:** ☐ Providence Medical Group Pediatric Subspecialties Clinic 3831 Piper Street Suite S-220 Anchorage, AK 99508 Phone: 907-212-4824 Fax: 907-212-4831 ☐ Name: _____ Phone: _____ Address: _____ Fax: _____ **Sent by:** ☐ **Secure Fax** ☐ **Mail to address above** ☐ **It will be picked up** ☐ **MyChart Patient Portal** *For our patient protection, it is our policy **NOT** to send records to unsecure fax numbers or email address. Records may be picked up at our office if being released to a patient or parent/legal guardian.*
REQUESTED INFORMATION	**Specify Providence Clinic(s)**: ☐ ENDOCRINE ☐ GASTROENTROLOGY ☐ PEDIATRIC ☐ PULMONARY ☐ NEPHROLOGY ☐ NEUROLOGY/NEUROSCIENCES ☐ RHEUMATOLOGY *Please check type of information to be released:* ☐ Complete Records ☐ Records for the following dates: From: _____ To: _____ ***Or** Specific Information* ☐ History & Physical Exam ☐ Radiology/Imaging Report ☐ Chart Notes ☐ Immunization Record ☐ Sleep Study ☐ Consultation Notes ☐ Laboratory Results ☐ Other:_____ **Any information protected by Federal Law must be specifically requested by initialing below:** ☐ Mental/Behavioral Health _____ ☐ Drug/Alcohol Abuse _____ ☐ HIV/AIDS Information _____ ☐ STD Treatment _____
PURPOSE	**Why are you requesting this disclosure?** ☐ Continuity of Care ☐ Legal Request ☐ Personal Records ☐ Insurance/Benefit ☐ Government ☐ Treatment ☐ Other: _____

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: Expiration: This authorization will expire in six (6) months from the signature date, unless an alternative date is provided here: ____/____/____ **Revocation:** I understand that I may revoke in writing at any time by completing a form available at PMG Pediatric Subspecialty. If I revoke this authorization, the revocation will not apply to information that has already been released before revocation and where authorization was obtained as a condition of insurance coverage.

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws or regulations, including HIPAA and the Privacy Act of 1974. A photocopy/fax of this form is as valid as the original.

Signature: _____ **Printed Name:** _____ **Date:** _____

Relationship to patient: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: _____

Office use only: To be completed by PMG Staff
Date Received: _____ Date Completed: _____ Sent by: ☐ Mail ☐ Fax ☐ Pick-up Staff Initials: _____