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AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

NAME: PATIENT'S DATE OF BIRTH:
PATIENT'S ADDRESS:
CITY: STATE: ZIP CODE:

HIV / AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initial: Date:

PLEASE CHECK APPROPRIATE BOX

Form with two checkboxes: I hereby authorize THE ALASKA BONE & JOINT INSTITUTE to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW. I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to THE ALASKA BONE & JOINT INSTITUTE, P.C.

(NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON / TO RECEIVE / RELEASE RECORDS)

NAME:
ADDRESS:
CITY: STATE: ZIP:
PHONE: FAX:

Receive By: Mail Pick-up, number to call when ready

Please check type of information to be released:

- Complete Records History & Physical Progress Notes Care Plan
Treatment Record Radiology Reports Pathology Labs
Operative Reports Medication Record Hospital Reports
Other - please specify:

Purpose of the Request:

- Personal (at the request of the patient) Treatment Legal Insurance
Other, (specify)

Signature: Date:

If signed by legal representative, relationship to patient: