OrthoAlaska

Orthopedic Physicians Alaska | Pain Management at OPA| Foot & Ankle Surgeons| Primary Care Associates
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Authorization for the Use and Disclosure of Health Information

Patient Name: _____ Mailing Address (Required)_____
Patient Date of Birth: _____Phone#: _____

Release From (check one): ☐ O.P.A (Includes Pain Management and Foot & Ankle Surgeons,) **|** ☐ P.C.A **|** ☐ Another Physician's office (Provide information below)

Release To (check one): ☐ Another Physician's office (Provide information below) **|** ☐ Nurse Case Manager (Provide information below) **|** ☐ Attorney (Provide information below) **|** ☐ O.P.A (Includes Pain Management and Foot & Ankle Surgeons,) **|** ☐ P.C.A ****Requests for records to 3rd party entities will only be released directly to the patient to provide to the 3rd party.*
Name and Mailing Address **(Required)** _____Fax#_____
*Additional Space*_____

☐ To myself* to be picked up in ☐Anchorage ☐Wasilla ☐Eagle River

☐ To myself to be mailed/emailed to me: _____

Date needed by: _____ * I Authorize _____to pick up my records on my behalf

	Description:		**Date Range: _____ to _____**
☐	Entire medical records, Including Radiology Imaging*	☐	Emergency Department Report(s) only
☐	Entire medical records **NOT** Including Radiology Imaging	☐	Operative Report(s) only
☐	Chart Note(s) only	☐	Laboratory Test(s) only
☐	Radiology Report(s) only	☐	Billing Record only
☐	Radiology Imaging only* (We can share imaging via Nuance Powershare)	☐	Other: _____

First physical copy of records/CD Imaging are free to all patients, any additional request(s) within the same calendar year for duplicate records may incur supply and labor fees

This consent for release of **Protected Health Information** is good for **1 year**.
I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with this consent. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent and in the manner indicated and authorized herein.

I acknowledge that the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse. **YOU MUST INITIAL HERE: _____ IF YOU DO NOT WANT THIS INFORMATION RELEASED.**

I understand that I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. If the requester or receiver is not a health plan or a health care provider, the released information may not be covered by Federal Privacy regulations; the information described above may be re-disclosed and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

I further understand and agree that if I direct OrthoAlaska LLC to mail my records to me or another provider that the records will be mailed regular U.S.P.S Mail.

_____ _____

Signature of Patient or Patient's legal guardian **Date:**

For administrative use only- ROI Received by: _____
Date Completed: _____ Completed by: _____
Records were: ☐Mailed ☐Picked up ☐Faxed ☐Emailed Faxed to# (If different from above): _____
Radiology Imaging: ☐Mailed ☐Picked up ☐ Pushed ☐Emailed