AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

Patient's Name	Date of Birth
Address	Social Security Number (last 4 digits only) XXX-XX-
City State Zip Code	Phone Number

I hereby authorize ______________________________________ to disclose my individually identifiable health information as described here to:

Alaska Breast Care and Surgery, LLC
3851 Piper Street, Suite U-462
Anchorage, AK 99508
Fax: 907-562-6267

The purpose(s) for which this disclosure is authorized:

Medical Care Insurance Other: ____________________________

TYPE OF INFORMATION TO BE RELEASED:
(This will be limited to the most recent information unless otherwise stated.)

All my medical records
Mammography
Breast MRI
Progress Notes
Pathology Reports
Lab Reports
History & Physical
Other: ____________________________

I understand that the information to be released or obtained may include mental health, substance abuse treatment, and/or HIV/AIDS-related information in accordance with Federal and State privacy and confidentiality laws, except as indicated below:

No Mental Health No Substance Abuse Treatment Information No HIV/AIDS Information

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I understand that:

1. Treatment and payment will not be conditional on whether I provide authorization for any requested disclosure by my healthcare provider.
2. I may inspect or receive a copy of my Protected Health Information (PHI) described by this authorization. I further understand that there may be a fee associated with copying my records, not to exceed what is authorized by Federal and State law.
3. This Authorization is voluntary and that I have the right to refuse to sign it.
4. I may revoke this Authorization at any time by providing a written notice of revocation. I understand that if I revoke this Authorization, I must do so in writing and present my written revocation to the healthcare provider for whom the Authorization was given. I understand the revocation will not apply to information that has already been released in response to this Authorization. I understand that the

revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. Unless otherwise revoked, this Authorization will expire on _______/_______/_______ or six (6) months after being signed.
6. The information disclosed pursuant to this Authorization, **except** information protected by Federal and/or State regulations pertaining to confidentiality of drug and alcohol abuse/treatment records, AIDS/HIV, and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by Federal/State privacy regulations or other applicable Federal or State laws.
7. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
8. My personal health information will be released in a paper format unless otherwise specified.
   Electronic Copy
9. If I have any questions about disclosure of my health information, I can contact the Practice Manager or Health Information Management Director.

Signature: ____ Date: _______/_______/_______

Relationship to Patient: ____

DRUG AND ALCOHOL ABUSE TREATMENT INFORMATION:
Federal (42 CFR Part 2) and State (AS 47.37.210) regulations prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by State law. A general authorization to release information is NOT sufficient for this purpose.

MENTAL ILLNESS INFORMATION:
State law (AS 47.30.845) prohibits any further disclosure of mental illness information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by State law. A general authorization to release information is NOT sufficient for this purpose.

SEXUALLY TRANSMITTED DISEASE INFORMATION (Includes HIV/AIDS)
State law (AS 18.15.310) prohibits further disclosure of this information without specific written consent of the person to whom the information pertains, or the parent or legal guardian of a minor child to whom it pertains, unless otherwise permitted by State law. A general authorization to release information is NOT sufficient for this purpose.