



ALASKA REGIONAL HOSPITAL

2801 DeBarr Road
Anchorage, AK 99508
Ph: (907)264-1291 Fax: (866)999-0665

Patient Name: _____
Date of Birth: _____
Medical Record #: _____
Release to: (Name & Address)

I request and authorize Alaska Regional Hospital or (facility or organization) _____ to release the information specified below to the individual/organization listed above. I understand this release is only for records dated on or before the date of this signed request/release. Any hospital visits following this date will need a new release filled out.

Is this request for psychotherapy notes? Yes No. If *yes*, then this is the only item you may request on this authorization. You must submit another authorization for other items below. If *no*, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> Basic Information		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/Delivery Summary	
<input type="checkbox"/> Physician Report(s)		<input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Cath Lab Flow Sheet	
<input type="checkbox"/> Laboratory Tests		<input type="checkbox"/> Transfer Forms		<input type="checkbox"/> Admission Form	
<input type="checkbox"/> Emergency Dept Report		<input type="checkbox"/> Physician Order		<input type="checkbox"/> Billing Record	
<input type="checkbox"/> Radiology Report		<input type="checkbox"/> All PHI (Complete medical record)		<input type="checkbox"/> Other:	
<input type="checkbox"/> Films					

I acknowledge, and hereby consent that the information released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **IF YOU DO NOT WANT THIS INFORMATION RELEASED, YOU MUST INITIAL HERE:** _____

This consent for release of **Protected Health Information** is good for 90 days unless otherwise stated _____. 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, and the attending physician are hereby released from legal responsibility or liability for the release of the above information. I understand that there is a charge of .25 cents per page and I will be invoiced.

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 no longer be protected by federal privacy regulations and may be redisclosed.

Purpose of Disclosure (Please check all applicable):

Further Medical Treatment Legal Proceedings Insurance Claim Other (Specify): _____

Is the request of Protected Health Information for the purpose of marketing? Yes No. If *yes*, will the recipient receive financial or in kind compensation in exchange for using or disclosing this information? Yes No. If *yes*, describe: _____

Signature of Patient

Date

Signature of Person Authorized to Sign for Patient

Relationship

Address

Phone Number

City, State, and Zip Code

Driver's License Number or Other Identification

Signature of Witness

Signature of Witness

**ALASKA REGIONAL HOSPITAL
RELEASE OF INFORMATION - GENERAL**

Correspondence Log #: _____



ROI
Form: ROI.01 tld 12/11

SCANNED