Alaska Center for Dermatology, P. C.

3841 Piper Street | Suite T4-020| Anchorage, AK 99508 | telephone 907.646.8500 | fax 907.646.9760

Authorization to Disclose
Protected Health Information (PHI)

Patient Name ____ **DOB** ________________

Parent/Responsible Party *(if applicable)* ____

- **I authorize release of the following:**

  ☐ All clinical visit records

  ☐ Specific clinical visit records from services rendered between the dates of ____________ and ____________.

  ☐ All PHI, including confidential

  ☐Specific PHI listed below

  ____

  ____

  ☐ All PHI except confidential selected below*

  (Note: While specific confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)

  *Confidential: HIV Test Results
  X-ray Reports Mental Health Treatment Records
  Lab Reports Clinic Notes for Doctors
  Alcohol & Drug Therapy
  Other (please specify): ________________________

- **Purpose of release:**

  ☐ Personal use

  ☐ Transfer of records to another provider

  ☐ Legal use

I authorize the Alaska Center for Dermatology to release my PHI to:

____

Mail to patient address on record.

Mail to other address:_________________________

____

Fax to: ___________________________

I will pick up. Call me at ______________________ when ready.

or

I authorize the Alaska Center for Dermatology to obtain my PHI from:

____

____

- **This authorization is valid for:**

  ☐ A continuing disclosure for treatment received on or prior to this request and for any future treatment of the type described above, not to exceed 12 months.

  ☐ A one-time disclosure for treatment received on or prior to this request.

I understand that I may revoke this authorization in writing at any time, except to the extent that release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. Unless I otherwise revoke this authorization in writing, it will expire either upon receipt of records or 12 months from the date of this authorization. At that time no express revocation shall be needed to terminate my authorization. I hereby release the Alaska Center for Dermatology or ________________________________ *(originating facility, if not Alaska Center for Dermatology)* **from any legal responsibility or liability for disclosures that may arise as a result of the use of the information contained in the PHI released.**

____ ____________________

Patient Signature (or Responsible Party) **Date**