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)

Note: Please fill out each section completely, and inquire if you have any questions. Thank you.

Patient Name ______________________________ **DOB** ______________

Phone Number(s) ______________________________

Parent/Legal Guardian *(if applicable)* ______________________________

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

  ☐ All PHI, including confidential

  ☐ Specific PHI from services rendered between the dates of ______________ and ______________.

  ☐ 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): ______________________________

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

____

Mail to: ______________________________

____

Fax to: ______________________________

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

OR

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

____

____

- **Purpose of PHI release:**

  ☐ Transfer of records to another provider

  ☐ Personal use

  ☐ Legal use

- **This authorization is valid for:**

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

  ☐ 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.

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 (or Legal Guardian) Signature **Date**