

ALASKA DIGESTIVE AND LIVER DISEASE
 3851 Piper Street Suite U-466. Anchorage, AK 99508
 Phone: 907-569-1333 Fax: 907-569-1433

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT	Name: _____ Birth Date: ____/____/____ Other Names Used: _____
FROM	<input type="checkbox"/> I request patient's information be sent by: <input type="checkbox"/> Dr. Ronald J. Boisen <input type="checkbox"/> Dr. Daryl M. McClendon <input type="checkbox"/> Dr. Jeffrey W. Molloy <input type="checkbox"/> Another health care provider name here: _____
PROVIDE TO	Who do you want the patient information to be sent to? Name: _____ Phone Number: _____ How do you want the medical information to be sent? <input type="checkbox"/> It will be picked up. <input type="checkbox"/> Fax to: _____ <input type="checkbox"/> Mail to this address: _____ <input type="checkbox"/> Other (describe): _____ <small>*Sending information by Fax increases privacy risks, as they involve increased risk of accidental disclosure. Information sent electronically may also be vulnerable to cyber-attack.</small>
REQUESTED INFORMATION	Please check or describe the health information that you would like disclosed: <input type="checkbox"/> Complete Record <input type="checkbox"/> Discharge Summaries <input type="checkbox"/> History & Physical Exams <input type="checkbox"/> Consultations <input type="checkbox"/> Physician Reports <input type="checkbox"/> Radiology & Imaging Reports <input type="checkbox"/> Medications Records <input type="checkbox"/> Pathology Reports <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Records for the following dates or treatment: _____ <input type="checkbox"/> Other: _____ Specific Sensitive Information needs to be initialed to be disclosed: ___Mental/Behavioral Health Treatment___Drug/Alcohol Abuse___HIV/AIDS Information___STD Treatment
PURPOSE	Why are you requesting this disclosure? <input type="checkbox"/> Personal Use <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Continuation of Care <input type="checkbox"/> Second Opinion <input type="checkbox"/> Other: _____
VALIDITY	Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ____/____/____ Revocation: An authorization may be revoked at any time by written notice to Alaska Digestive and Liver Disease Management. Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.
PATIENT RIGHTS	I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse to sign this authorization - ADLD may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by ADLD by contacting Health Information Management. I may be charged a reasonable fee for copying costs.
REQUESTOR	I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original. Signature: _____ Date: ____/____/____ Print Name: _____ Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Legally Authorized Representative <input type="checkbox"/> Other: _____

OFFICE USE ONLY: Verification Method: _____ Priority or Archive
 Sent by: PU Mail Fax Email Other: _____ Date Sent: ____/____/____ Staff Initials: _____