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

■ **I request patient's information be sent by**:
■ Dr. Daryl M. McClendon
■ Dr. Jeffrey W. Molloy
■ Dr. Austin T. Nelson
■ Dr. Martin P. Kaszubowski
■ 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?

■ It will be picked up.
■ Fax to**:**

■ Mail to this address: _____

■ Other (describe)**:**_____

*****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.

REQUESTED INFORMATION

Please check or describe the health information that you would like disclosed:

■ Complete Recor ■ Discharge Sum naries ■ History & Physical Exams
■ Consultations ■ Physician Repor s ■ Radiology & Imaging Reports
■ Medications Rec ords ■ Pathology Repo ts ■ Laboratory Results

■ Records for the following dates or treatment**:**_____
■ 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?
☐ Personal Use ☐ Legal ☐ Insurance ☐ Continuation of Care ☐ Second Opinion ☐ 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: ☐ Self ☐ Parent/Guardian ☐ Legally Authorized Representative ☐ Other: _____

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