MAT-SU SURGICAL ASSOCIATES

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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME:

Last First Middle (Previous Name)

Mailing Address City State Zip

Date of Birth Cell Phone # Social Security # (optional)

RELEASE OF INFORMATION FROM:

NAME/ORGANIZATION

Street Address City State Zip

Phone # Fax #

RELEASE INFORMATION TO:

NAME/ORGANIZATION

Street Address City State Zip

Phone # Fax #

INFORMATION TO BE RELEASED:

( ) History & Physical ( ) Lab Results ( ) X-Ray reports
( ) Discharge Summary ( ) Operative Reports ( ) X-Ray films
( ) Progress notes ( ) Pathology Reports ( ) Other _____
( ) ALL RECORDS*

*ALL records may include diagnoses, consultations, evaluations, tests and results, medications, treatment for all medical, psychiatric impairments, drug and alcohol abuse/dependence, hepatitis, tuberculosis, sexually transmitted diseases, HIV, AIDS & Compliance or non-compliance with treatment prescribed.

This authorization shall be in force and effect until _____ or _____
(Event that relates to the patient or the purpose of the use or disclosure)
at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the Privacy Officer, Tonya Media, at 2490 S. Woodworth Loop, Suite 450 Palmer AK 99645.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (parent, guardian, etc.)