Aurora ENT
3340 Providence Dr., Suite 461, Anchorage, AK 99508
Phone: (907) 277-6673 • Fax: (907) 277-6695

Patient Name: _____ **Date of Birth:** _____
Address: _____
Phone Number: _____ **Social Security Number:** _____

I hereby authorize Aurora ENT to: _____ Release Information To: _____Obtain Information From:

Person/Physician/Agency: _____
Address: _____
Phone Number: _____ Fax Number: _____

To be: _____Mailed _____Faxed _____Picked-up

MEDICAL INFORMATION TO BE SENT (Please check all that applies):

_____Specific Dates: _____
_____Entire medical records
_____Hospital records/reports
_____Emergency & urgent care records/reports
_____Pathology reports
_____Radiology reports
_____Laboratory reports
_____Billing statements or financial summary
_____Other: _____

FOR THE PURPOSE OF:

_____Treatment
_____Payment
_____Health Care Operations
_____Personal Records
_____Legal Request

****The following items must be initialed to be included in the use or disclosure of other health information****

_____HIV/AIDS related health information and/or records
_____Mental health information and/or records
_____Genetic testing information and or records
_____Drug/Alcohol diagnosis, treatment and/or referral information. (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.
_____Psychotherapy notes. (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.

I understand that I have the right to revoke this authorization at anytime except to the extent that the office has already taken action in reliance on the authorization. To revoke this authorization, I must submit a written notice to Aurora ENT. Unless revoked earlier, this authorization will expire one year from the date signed. **Date expires: _____**

I also understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by Federal Privacy regulations, the information described above may be re-disclosed and no longer protected by the privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. This facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient or Patient's Legal Representative **Date**

_____ _____
Witness **Date**