Authorization to Use and/or Disclose Health Information

I, (name of patient) _____, authorize _____ to use and/or disclose my health information as identified below to: **Mark E. Richey, M.D., 1200 Airport Heights Drive Suite 205, Anchorage AK 99508, Fax (907) 272-2262 Phone (907) 272-4443**

For the following purpose(s): (describe each purpose; if requested by patient and no purpose is identified, then may state "at the request of the individual") _____

_____

_____

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

_____ Please send the entire medical record (all information) to the above named recipient.

_____ All hospital records (including nursing and progress notes)

_____ Transcribed hospital reports

_____ Medical records needed for continuity of care

_____ Most recent five year history

_____ Emergency and urgent care records

_____ Clinical office chart notes

_____ Dental records

_____ Laboratory reports

_____ Pathology reports

_____ Diagnostic imaging reports

_____ Billing statements

_____ Other _____

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.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to (identify the person/entity to whom written notice of revocation must be given) _____. Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (insert applicable date or event of expiration) _____.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Signature of Individual or Individual's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Individual

(A copy of this signed form will be provided to the individual and/or the individual's legal representative.)