Denali Orthopedic Surgery P.C.
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____
Date Of Birth: _____ Day Phone #: _____

I authorize release of my records
TO: _____
FROM: _____

For the following reason: ☐Personal ☐Continued care with another physician ☐ Legal ☐Other: _____
Date Needed by: _____

Type of information to be disclosed: Date(s) of Treatment: _____ Body Part: _____
☐Chart Notes ☐X-ray Disc ☐Operative Report ☐Radiology Report ☐All Records ☐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.)

I request my records be provided in the following format: ☐ Paper copy ☐ Electronic Copy

☐ Please call me when records are ready to pick up at this number: _____
☐ Please mail my records to this address: _____
☐ Please fax my records to this number: _____
☐ Please email my records to this address: _____

I understand this authorization with expire on: _____ (If not specified, authorization will expire one year from date signed.)

I understand that:

- Authorizing the disclosure of this information is voluntary. My right to treatment, payment, enrollment, or eligibility for benefits is not contingent on signing this form.
- I have the right to revoke this authorization at any time by submitting a ***written*** request to the address provided at the top of this form. I understand that this will not apply to information that has already been released as a result of this authorization.
- Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the person or facility listed above as receiving this information is not covered by federal health privacy regulations, the released information may be re-disclosed and may no longer be protected by federal or state law.

_____ _____ _____
Signature of Patient or Patient's Legal Representative Date ID Verification: Document and Number

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For administrative use only: Chart Number: _____
Records processed by Employee Initial and Date: _____
Records: _____ Faxed _____ Mailed _____ Emailed _____ Picked up
(If picked up, Employee Initials and Date_____)

Provider Review: