AWC
Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

*Release of Information **FROM** Anchorage Women's Clinic*

Patient Name: _____ **Date of Birth**: _____ **Phone Number**: _____

Previous Name: _____ Last 4 Digits of Social Security #: _____

I authorize Anchorage Women's Clinic, LLC (AWC), to release all or part of my medical records to:
(If applicable, please include name of physician AND name of the practice.)

Name: _____

Address: _____

Phone: _____ **Fax:** _____

Options for Receiving Records: **First** patient copy is **complimentary**. Charges may be

- ☐ Mail
- ☐ Will Pick Up
- ☐ Fax
- ☐ Paper
- ☐ CD (default)

Information to be released:

- ☐ **Labs / Pathology**
- ☐ **Imaging Reports**
- ☐ **Office Visits**
- ☐ **Medication List**
- ☐ **Immunizations**
- ☐ **Surgical Reports**
- ☐ **OB Records**
- ☐ **All Records** (if this is selected, only the last 2 years will be released unless otherwise specified)
- ☐ **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.) _____
- ☐ **Genetic testing/records** (If this authorization includes the use of other records, this **MUST** be initialed.) _____
- ☐ **Psychotherapy notes** (If this authorization is for psychotherapy notes, then it cannot be combined with any other authorizations.)

Approved and processed by _____

For the purpose of:

- ☐ **Personal Copy**
- ☐ **Referral**
- ☐ **Legal**
- ☐ **Insurance / Payment of a claim**
- ☐ **2nd Opinion / Consultation**
- ☐ **Transfer due to discharge or relocation (circle one)**
- ☐ **Continuation of care**
- ☐ **Changing Physician to:** _____

Reason for changing physician: _____

I acknowledge the information to be released may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). My health record may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time by giving written notice to AWC. I understand the revocation will not apply to information that has already been released in response to this authorization, and the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In the absence of a revocation, this specific authorization expires on _____ (if left blank, will expire 180 days from date of my signature.) Maximum for authorization is one (1) year from the date of signature.

I understand once the above information is disclosed, it may be redisclosed by the recipient and that the released information may not be further protected by federal privacy laws or regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to obtain healthcare treatment.

_____ _____

Signature of Patient or Patient's Legal Representative — Date

_____ _____

Print name of legal representative (if applicable) — Relationship of Legal Representative to Patient

FOR INTERNAL USE ONLY Processed by: _____

Received by: _____ Date: _____ # of Pages: _____

Date: _____ Records were: ☐Mailed ☐Picked Up ☐ Faxed to #

Records to be picked up on: _____

Receipt for AWC Records: ☐ **ID Checked**
I hereby acknowledge receipt of the above noted medical records:

_____

PATIENT COPY OF ROI: ☐ **Given** ☐ **Declined**

RESEARCH AND COPY FEES:		**FEE $** _____
1-50 pp	$50	**COLLECTED** ☐**YES** ☐**NO**
50-75 pp	$75	*Additional fees will be*
75-100 pp	$100	*applied to legal and*
100+	Invoiced	*insurance requests.*

www.anchoragewomensclinic.com
3260 Providence Dr., Suite 425
Anchorage, AK 99508
Phone 907.561.7111 Fax 907.770.7891