AWC
Anchorage Women's Clinic
ANCHORAGE AND EAGLE RIVER

# *Release of Information TO 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 request my health information from:**

(If applicable, please include name of physician AND name of the practice)

Dr: _____ Practice Name: _____

Address: _____

Phone: _____ Fax: _____

**I release Anchorage Women's Clinic, LLC (AWC), to request the following information:**

**Dates of service from: _____ to: _____**

| | | |
|---|---|---|
| ☐ **Labs/Pathology** | ☐ **Surgical Reports** | ☐ **Medication List** |
| ☐ **Imaging Reports** | ☐ **OB Records** | ☐ **Office Visits** |
| ☐ **Pap Reports** | ☐ **All Records (Last 5 Years)** | ☐ **Other** |

**The following MUST be initialed to be included in the use or disclosure of other records:**

_____ **Genetic testing information and/or records**

_____ **HIV/AIDS related health information and/or records**

_____ **Drug/alcohol diagnosis, treatment and/or referral information** (Federal regulation require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information)

_____

_____ **Behavioral Health and/or counseling records** (request another ROI. Request for psychotherapy records cannot be combines 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 AWC. Unless revoked earlier, this authorization will expire 180 days from the date of signing below or upon _____.

_____ _____

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**

**Received by:** _____

**Date:** _____

**Faxed on:** _____

**Date records received:** _____

**Processed by:** _____

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