ORTHOPEDIC PHYSICIANS
ALASKA
A Division of OrthoAlaska

3801 Lake Otis Pkwy, Suite 300
Anchorage, AK 99508
Ph# (907) 562-2277 Fax# (907) 563-3460

Patient Name: _____
Date of Birth: _____

I authorize: (Who is releasing the records) ☐ Orthopedic Physicians Alaska And/Or ☐ Other_____
to Release Protected Health Information to (Where are the records going):

☐Myself **or** ☐ O.P.A. **or** ☐ Other _____
at Fax# _____ **or** Regular U.S. Mail address _____

or E-mail _____ **or** Person will pick up in ☐ Anchorage ☐Wasilla
Date Needed By: _____

	Description:		**Date Range: _____ to _____**
□	Entire medical records, Including CD images.	□	Emergency Department Report(s)
□	Entire medical records **NOT** Including CD images	□	Operative Report(s)
□	Chart Note(s)	□	Laboratory Test(s)
□	Radiology Report(s)	□	Billing Record
□	Radiology CD Imaging (**cannot** be E-Mailed)	□	Other:_____

This consent for release of **Protected Health Information** is good for **1 year** unless otherwise stated. **Date Expires:** _____. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in compliance with this consent. 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 and in the manner indicated and authorized herein.

I acknowledge that 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. **YOU MUST INITIAL HERE: _____ IF YOU DO NOT WANT THIS INFORMATION RELEASED.**

I understand that I may refuse to sign this authorization and that it is strictly voluntary. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. If the requester or receiver is not a health plan or a health care provider, the released information may not be covered by Federal Privacy regulations; the information described above may be re-disclosed and no longer protected by the Health Insurance Portability and Accountability Act of 1996.

I further understand and agree that if I direct OPA to mail my records to me or another provider, that the records will be mailed regular U.S. Mail.

_____ _____
Signature of Patient or Patient's legal guardian **Date:**

_____ _____
Witness **Date:**

For administrative use only-

Date Completed: _____ Completed by: _____
Records Were: □Mailed □Picked up □Faxed □Emailed Faxed to# (If different from above): _____
CD Imaging: □Mailed □Picked up □ Pushed
Completed Form to Be Filed in Patient's Record