Family Practice Physicians
10301 Glacier Hwy · Juneau, AK 99801
Tel (907) 789-2910 Fax (907) 789-5545

Authorization for use or disclosure of Protected Health Information

Patient information:
Patient Name: _________________________________ Date of Birth: ________________
Social Security#: ______________________________ Daytime Phone: _____________

Requesting records from:
Name of Physician: ____

Mailing Address: _______________________________ City: ____________ State: ____

Records to be released to:
Name: ____

Mailing Address: _______________________________ City: _____________ State: ___

I authorize my physician and/or administrative and clinical staff to use and/or disclose:
Type of information to be released:
□Most recent progress notes (please specify dates):______________________________
□Lab Reports/X-ray Reports (please specify dates):_____________________________
□Other (please specify): ____
□Entire Health record
□Billing records
□Immunization records

Purpose of request: □Medical Treatment □Legal □Insurance □Other___________

I understand that my record may contain information regarding the diagnosis or treatment of a confidential illness including, but not limited to mental health, genetic, HIV, AIDS, drug & alcohol. I give my specific authorization for these records to be released. I release Family Practice Physicians from any legal responsibility or liability that may result from this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. Unless stated otherwise, authorization is valid twelve (12) months from the date of signature and may be revoked in writing at any time.

____ ______________________
Signature of Patient or Personal Representative Date

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Printed Name of Patient or Personal Representative
(If personal Representative, Description of Authority)