Full Spectrum Health

307 E. Northern Lights Blvd. Ste 201 Anchorage, AK 99503 P:907-229-9766 F:(855)851-6143

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Identification:

Printed Name: _____ Date of Birth: _____

Previously Used Name: _____

Address: _____

Home Telephone #: _____ Cell Telephone #: _____Work Telephone #: _____

Release To/From: Name: _____ Phone: _____

Address: _____Fax: _____

Release To/From: Name: **Full Spectrum Health** Phone**: (907)229-9766**

Address: **307 E. Northern Lights Blvd. Ste 201 Anchorage, AK 99503** Fax: **(855)851-6143**

Information to be Released:

From (Date): _____To (Date): _____

This Request and Authorization Applies to:

___ History & Physical Exams ___ Medication List ___ Psychiatric Reports

___ Discharge Summary ___ Clinical/Procedure Note ___ Complete Health Record

___ Treatment Plan ___ Laboratory Test Results. ___ Demographics

___ Assessment/Evaluations Other: _____

Purpose of records request (circle all that apply): Ongoing treatment Consultation Collateral Information

Diagnostic Clarification Telephonic Communication Personal Other

Terms:

I understand that authorizing the disclosure of specified information is voluntary and completion of this form is not necessary to ensure treatment. I understand that the information in my record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse and treatment, psychiatric care or other sensitive information.

Expiration & Right to Revoke Authorization:

I understand that at any time I may revoke this authorization by submitting a notice in writing to Full Spectrum Health. This authorization will expire 12 months from the date of which it was signed unless revoked earlier or at the following date: _____

Re-Disclosure

I understand that one the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

Signature: _____Date: _____

If signed by legal representative, relationship to patient: _____