



Arete Family Medicine - Anchorage
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Permission To Request Medical Records

Patient Name: _____ Date of Birth: _____

I am the: Patient Parent/guardian Other: _____

I authorize **ARETE FAMILY MEDICINE – ANCHORAGE (AFM-A)** to request my medical records from:

Practice name: _____ Practice phone: _____

Practice address: _____

Request type: Fax to AFM-A Mail copy to AFM-A

Purpose of disclosure: Continuity of care Other: _____

By checking the boxes below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

- ALL MEDICAL RECORDS
- Chart notes: All From: _____ to _____
- Labs: All From: _____ to _____
- Radiology reports: All From: _____ to _____
- Immunization records Other (please specify): _____

PLEASE INITIAL the items below for this information to be included in the use or disclosure of other health information:

Federal regulations require a description of how much of what kind of information is disclosed. Federal law prohibits the re-disclosure of such information, only with authorization:

This Section Must Be Completed

___ Yes, disclose ___ No, do not disclose - HIV/AIDS related health information and/or records

___ Yes, disclose ___ No, do not disclose - Mental health information and/or records

___ Yes, disclose ___ No, do not disclose - Drug/alcohol diagnosis, treatment, and/or referral information

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon the following date (or condition, or event of expiration): _____

Exception to the extent that action has already been taken in reliance upon the authorization, I understanding that I may revoke this authorization at any given time by giving written notice. I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. **Please allow 10 business days for processing.**

Signature of Patient or Patient’s Legal Representative

Date

Print name of Legal Representative (if applicable)

Relationship of Legal Representative to Patient