ARETE PROVIDER NETWORK
Arete Family Medicine - Anchorage

Arete Family Medicine - Anchorage
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Permission To Distribute Medical Records

Patient Name: _____ Date of Birth: _____
I am the: ☐ Patient ☐ Parent/guardian ☐ Other: _____

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

Practice name: _____ Practice phone: _____
Practice address: _____
Request type: ☐ Fax to practice at _____ ☐ Mail copy to practice ☐ Pick up at 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