Alaska Foot & Ankle Specialists
4100 Lake Otis Pkwy Ste 312
Anchorage, AK 99508 • 907-569-3668

Alaska Foot & Ankle Specialists

Authorization for Disclosure of Health Information

I authorize Alaska Foot & Ankle Specialists to disclose the following information from the health records of:

Patient Name: _____ Date of Birth: _____
Address: _____
Phone: _____

Covering the period(s) of health care:

From (date) _____ to (date) _____
From (date) _____ to (date) _____

Information to be disclosed:

☐ Complete health record ☐ Discharge Summary ☐ History and Physical Examination ☐ Progress Notes
☐ Laboratory Tests ☐ Consultation Reports ☐ Photographs, videotapes, digital, or other images
☐ X-ray Reports ☐ Other _____

I understand that the information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information is to be disclosed to:

Name: _____
Address: _____
Phone: _____ Fax: _____

The purpose of this disclosure is for:
☐ My personal records ☐ Continuity of care with other provider(s)
☐ Other: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Alaska Foot & Ankle Specialists and that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:
_____

Alaska Foot & Ankle Specialists, its employees, officers, and doctors are hereby released from any legal responsibility or liability for disclosure of the above information to the extent I have indicated and authorized.

_____ _____
Signature of patient or legal representative Date

_____ _____
Signature of witness Date