

Denali Anesthesia, P.C.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I, **[name of patient]** _____, authorize **Denali Anesthesia, PC** to use and/or disclose my health information, as identified below, to **[name and address of recipient]**

_____ for the following purpose(s):

_____.

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

- _____ Anesthesia Medical Records
- _____ Anesthesia Billing statements

* The following items must be initialed to be included in the use or disclosure of other health information:
_____ *HIV / AIDS related health information and/or records
_____ *Mental health information and/or records
_____ *Genetic testing information and/or records
_____ *Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.) _____

_____ ***Psychotherapy notes** (If this authorization is for the use and/or disclosure of psychotherapy notes, then it cannot be combined with any other authorization.)

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Denali Anesthesia’s Privacy Officer. **Unless revoked earlier, this authorization will expire 180 days from the date of signature.**

I understand that I may inspect or copy any information to be used or disclosed under this authorization. I also 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 redisclosed and no

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longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Signature of Individual or Individual's Legal Representative

Date

Individual's Social Security Number [requested for verification]

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative to Individual

Mail this Request to: Denali Anesthesia, PC
Attn: Patient Records
P.O. Box 140227
Anchorage, AK 99514

Mail Written Revocation to: Denali Anesthesia, PC
Attn: Privacy Officer
PO Box 140227
Anchorage, AK 99514

***A copy of this signed form will be provided to the individual and/or the individual's legal representative.**