Providence Medical Park / 3841 Piper Street, Suite T300 / Anchorage, AK 99508 Alaska Regional Campus / 2925 DeBarr Road, Suite 250 / Anchorage, AK 99508
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Mat-Su Regional Medical Plaza / 2490 S. Woodworth Loop, Suite 401 / Palmer, AK 99645 Ph: (907) 745-9300 Fax (907) 745-9301
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Authorization to Use Disclose Protected Health Information

Patient Name:____ DOB: _______________________

Address: ____

____

Telephone: ____

Other names under which the Patient has been treated: _______________________________________

I authorize Alaska Urology and its employees, agents or associated healthcare practitioners to use or disclose the Patient's protected health information as described below.

1. **Relevant Time Period.** Alaska Urology may use or disclose information relating to healthcare provided during the following time period:

   Anytime.

   Healthcare provided between *(date)* __________________ and *(date)* __________________

2. **Types of Information.** Alaska Urology may use or disclose the following type(s) of information:

   Any information concerning the Patient's healthcare or payment during the relevant time period.

   Medical records concerning the Patient's healthcare during the relevant time period, including:

   Records from the Patient's chart *(e.g.,* history, examination, progress notes, lab results, diagnostic test results, operative reports, discharge summaries, photographs, *etc.)*

   Diagnostic images, films or other recordings *(e.g.,* x-rays, MRI scans, CT scans, *etc.)*

   Psychotherapy notes ***[Note: These cannot be combined with authorization for other records]***

   Billing and payment records for healthcare rendered during the relevant time period.

   Other: ______________________________

3. **Persons to Whom Disclosure Allowed.** Alaska Urology may disclose the information to the following:

   Name or description:______________________________________

   Address: ______________________________________

   Phone number: ______________________________________

   Fax number: ______________________________________

Name or description: ____

Address: ____

Phone number: ____

Fax number: ____

Name or description: ____

Address: ____

Phone number: ____

Fax number: ____

4. **Purpose.** Alaska Urology may use or disclose the information for the following purpose(s):

The disclosure is made at the Patient's request.

For a potential or pending legal proceeding.

I understand that I have the right to revoke this authorization at any time except to the extent that PROVIDER has taken action in reliance on this authorization. To revoke this authorization, I must submit a written revocation to:

Alaska Urology
3841 Piper St. Suite T300
Anchorage, AK 99501

I understand that information disclosed by Alaska Urology pursuant to this authorization may be re-disclosed by the entity who receives this information and may no longer be protected by privacy regulations.

This authorization will expire (may not exceed five-years). ________________________________

If no specific date or event is stated, this authorization will expire one (1) year from the date of this authorization.

I also hereby acknowledge that I have received Alaska Urology's Notice of Privacy Practices.

Patient Name: ____ DOB: ____________

Date: ______________________________

Electronic or Wet Signature: ____

Name: (if different than patient) ____________________________________ DOB: ____________

Authority or relationship to patient________________________________

By signing the form you are agreeing to the terms of the Release of Information (ROI) contained in this document.