-SOUTHEAST ALASKA UROLOGY-

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION

Patient Name: _____ Birth Date: _____

Address: _____

City / State/ Zip: _____

I HEREBY AUTHORIZE

Southeast Alaska Urology, 3000 Vintage Boulevard, Suite 207, Juneau, Alaska 99801

To **RELEASE** information TO_____

To **REQUEST** information FROM_____

Name of Individual: _____

Address: _____

City / State / Zip: _____Phone Number: _____ FAX: _____

INFORMATION TO BE DISCLOSED

Dates of treatment: _____to_____

_____Consultation	_____History & Physical	_____Lab Reports
_____Physical Rehab Notes	_____Discharge Summary	_____Operative Report
_____Pathology Reports	_____Radiology Reports	_____Radiology Disc
_____Medication List	_____ER Report	_____Verbal Exchange

_____ _____ _____

Signature of Patient or Legally Responsible Party Relationship to Patient Date

By signing this form, I give my specific authorization for release of the records as indicated above. If the information to be released pertains to alcohol or drug abuse, I understand the confidentiality of the information is protected by federal law (42 CFR, Part 2). Furthermore, I understand that my records my contain information regarding the diagnosis of HIV, AIDS, other sexually transmitted disease, drug abuse, alcohol use, mental illness or psychiatric treatment. Prohibition on Redisclosure: this information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42 CFS Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent to the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose. Federal regulation state that any person who violates any provision of this law shall be fined not more than $500, in case of first offense and not more than $5000 in the case of each subsequent offense