MODERN
GYNECOLOGY

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize :_____
(Name of individual or organization)

to disclose health information from the medical record(s) of:

Patient name: _____

Date of birth: _____

Address:_____

_____

Date(s) of treatment: _____

Release information to: Modern Gynecology

Address: 3851 Piper St, Suite U464, Anchorage, AK 99508

p.907-339-0363 f.907-339-2363

I am requesting the following information to be released:

Initial all that apply:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____ Other: _____Labs _____Slides _____X-rays

_____ Medication History

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment

_____ Other (specify reason): _____

Unless revoked earlier, this authorization will expire 180 days from the date of signing or upon (inset date or event of expiration)_____.

This consent permits the Practice to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ _____

(Print patient's name) Date

_____

(Signature of patient)

_____

(Signature of legally authorized person if other than patient)

3851 Piper St. Ste U464, Anchorage, AK 99508
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