OTHER OFFICE RELEASING RECORDS TO MODERN GYNECOLOGY & SKIN

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____

*(Name of individual & organization – **OTHER OFFICE** you've previously been seen at)*

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

Patient Name: _____ **DOB:** _____

Address: _____

Date(s) of Treatment: _____

*(Include any records, imaging, or labs relating to care within the last **2–5 years**)*

Release Information To:

MODERN GYNECOLOGY
3851 Piper St, Suite U471, Anchorage, AK 99508
p. 907-339-0363 | f. 907-339-2363

Information to be Released (check all that apply):

- ☐ Office/ Clinical Notes
- ☐ Procedure Notes
- ☐ Lab/ Path Reports
- ☐ Imaging Reports
- ☐ Billing
- ☐ Other: _____
- ☐ HIV/ AIDS or related info (*special consent & signature required*) _____

Purpose of Release:

- ☐ Continuing Medical Treatment
- ☐ Litigation/ Review
- ☐ Insurance (Company): _____
- ☐ Other: _____
- ☐ Personal Use

Expiration: This authorization expires 180 days from the date of signing or upon: _____.

This consent allows Modern Gynecology to use/disclose health information for treatment, payment, or healthcare operations as described in the Practice's *Notice of Privacy Practices*. I understand I may review the Notice, request restrictions (though the Practice is not required to agree), and revoke this consent in writing at any time except where action has already been taken. No further information will be released without additional written authorization.
I understand these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE Modern Gynecology, its employees, or agents in connection with the authorized disclosure of these records.

Patient Name (print): _____

Signature of Patient: _____ **Date:** _____

If signed by legal representative, print name/relationship: _____

Signature: _____ **Date:** _____