Alaska Heart & Vascular Institute
3841 Piper Street Suite T-100
Anchorage, AK 99508
Phone: 907-561-3211
Fax: 907-561-4652

Medical Record Release Authorization

Patient Name: ______________________________ Maiden Name: ____________________

Date of Birth: ________________ Home Phone: ________________ Cell/Work Phone: ________________

Address: ______________________________ City/State/Zip: ______________________

Email Address: ____

A) I hereby authorize records FROM:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ____________ Fax: ____________

B) To be released TO:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ____________ Fax: ____________

C) For the purpose of:

_____ Litigation

_____ Insurance

_____ Self/Personal Copy

_____ Transfer/Continuity of Care

_____ Disability

_____ Work Comp

_____ Other

Date Range: from ______________________ to ______________________

- ☐ Physician Office Notes
- ☐ Operative/Procedure Reports
- ☐ Immunizations
- ☐ Radiology Imaging Reports
- ☐ Cardiology Testing/EKG Reports
- ☐ Device Check/Holter/CEM Reports
- ☐ Laboratory/Pathology Reports
- ☐ Other: ____

Send via: ☐ Mail ☐ Fax ☐ Other: ____

- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
- I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

________________ ____ ****Subject to Fees**
(Date) **(*Signature of Patient/Parent/Guardian or Authorized Representative)**

This authorization will expire one year from the above date unless I specify an expiration date: ______________________
(Expiration date not to exceed 3 years)

***Authorized Representative:** Durable Power of Attorney, Guardianship/Conservatorship must be on file with AHVI; if not, copies must be included with request.
****PLEASE READ** Fee Information*:* Alaska Heart & Vascular Institute reserves the right to charge the medical record state fee structure as set forth in the state statue. Copy charges plus postage will be invoiced with all necessary directions to receive your records. By signing this authorization, you are agreeing to pay Alaska Heart & Vascular Institute for your records. In the case of continuity of care or personal copy to patient, we may transfer a minimal portion of your records as a courtesy.