3600

SWEDISH

PROVIDENCE Health & Services

Outgoing

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

For what States: ☐ Alaska ☐ Montana ☐ Washington

I authorize PH&S or Swedish to use and disclose a copy of the specific health information described below regarding:

Patient's Name: _____ DOB: _____

Patient's Address: _____ Phone: _____

To be disclosed to: (Name of Recipient(s)): _____

Recipient's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I am requesting information from the following facility(s):

Hospitals Name (List) and Phone Number	Clinics Name (List) and Phone Number
	Providence Family Medicine Center 907-212-9815 (P)
	1201 E 36th Ave Anchorage AK 99508 907-562-1603 (F)

For the range of dates from: _____ to: _____

For information related to the following diagnosis or injury: _____

Information to be disclosed:

☐ History & Physical	☐ Discharge Summary
☐ Operative Report	☐ Emergency Department Report
☐ Diagnostic Reports (lab, x-ray, EKG, etc.)	☐ Progress Notes

☐ Other (specify): _____

For the purpose of: _____

Unless revoked, this authorization expires in 180 days or on this Date: _____

Terms: This authorization, unless expressly limited by me in writing will extend to all aspects of testing and/or treatment of sexually transmitted diseases, AIDS, HIV Infection, alcohol and/or drug abuse, mental health conditions or other sensitive information.

Patient Signature: _____ Date: _____

Patient Representative Name: _____ Date: _____

Patient Representative Signature: _____ Relation to Patient: _____