Grant Searles, MD, FACS

DBA: Anchorage Surgical and Bariatric

1200 Airport Heights Drive, Suite 350 Anchorage, Alaska 99508

Phone: 907-277-1197 **Fax:** 907-277-1139

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

For the **purpose** of: ☐ Personal (at the request of the patient) ☐ Treatment ☐ Workers Comp. ☐Insurance

☐ Legal ☐ Government ☐ Other (specify) ____

Patient's Name: ______________________________ Date of Birth: ______________________________

Previous Name: ______________________________ Social Security #: ______________________________

I request and authorize release from:____

Release To:

Name: Grant Searles, MD, FACS Phone: 907-277-1197

Address: 1200 Airport Heights Drive Suite 350 Fax: 907-277-1139

City: Anchorage State: Alaska Zip Code: 99508

For date(s) of service:___________ to ________________

This request and authorization applies to:

☐ Emergency Reports ☐ Consultation ☐ Pathology Reports ☐ History and Physical ☐ Discharge Summary

☐ Laboratory Reports ☐ Radiology reports ☐ Clinic Reports ☐ Radiology Films ☐ Problem/ Medication Lists

☐ Immunization Chart ☐ EKG ☐ Other

I acknowledge that the data to be released MAY INCLUDE material that is protected by Federal Law. My initials and my signature below authorize release of the following type of information.

Terms:

____ I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand the information in my health record may include records relating to sexually transmitted diseases, drug and/or alcohol abuse treatment, psychiatric care or other sensitive information.

Expiration and Right to Revoke Authorization:

____ Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to Dr. Searles office. Unless revoked earlier, this authorization will expire six months from the date on which it was signed, or upon the following **date or event:_________**

Re-Disclosure:

____ I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

HIPAA COMPLIANT

Printed Name:______________________________ DOB:________________

Signature:__________________________________ Date:________________

To be completed by Office Staff (document all requests) Date Received: ___________ Date Completed____________

Materials Sent_______________________________________

Completed By: _______________________________________

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Release To:

Name: ____ Phone:____________

Address: ____ Fax:____________

City: __________________________ State: __________________ Zip Code:___________

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