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 <u>purpose</u>	of: ☐ Personal (at the reque	st of the patient) Treatment	☐ Workers Comp. ☐ Insurance
☐ Legal ☐ Gove	rnment Other (specify)		
		Date of Birth:	
request and authorize releas	se 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	
For date(s) of service:	to		
This request and authorization ap	pplies to:		
☐ Emergency Reports ☐ Cons	sultation	istory and Physical □ Discharge Summary	
☐ Laboratory Reports ☐ Radio	ology reports □ Clinic Reports □ R	adiology Films	s
☐ Immunization Chart ☐ EKG	□ Other		
I acknowledge that the	data to be released MAY IN	CLUDE material that is protected	d by Federal Law. My initials and
my signature below aut	thorize release of the followi	ng type of information.	
treatment. I understand the	=	nformation is voluntary and I need not by include records relating to sexually tr rmation.	
submitting a notice in writing	at action has already been taken in	reliance on this authorization, at any ti ed earlier, this authorization will expire	
Re-Disclosure: I understand that once by federal privacy laws or reg		it may be subject to re-disclosure by th	ne recipient and no longer protected
HIPAA COMPLIANT			
Printed Name:Signature:	DOB: Date:		
J.D G. C			

To be completed by Office Staff (document all requests) Date

Received: _____ Date Completed__

Materials Sent____ Completed By: ___

(Rev. 05/20)

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:	Date of Birth: _	Date of Birth:		
Previous Name:	Social Security #:	Social Security #:		
request and authorize release from:	Grant Searles, MD, FACS			
Release To:				
Name:		Phone:		
Address:		Fax:		
	State:			
For date(s) of service: to				
This request and authorization applies to:				
☐ Emergency Reports ☐ Consultation	□ Pathology Poports □ History and Physical □ Discharge Summa			
	Li Facilology Reports Li History and Physical Li Discharge Summa	ry		
☐ Laboratory Reports ☐ Radiology repor				
	ts Clinic Reports Radiology Films Problem/ Medication L			
	ts Clinic Reports Radiology Films Problem/ Medication L	ists		
□ Immunization Chart □ EKG □ Other I acknowledge that the data to my signature below authorize I Terms: □ I understand that authorizing the	ts	ists ed by Federal Law. My initials and ot sign this form to ensure		
□ Immunization Chart □ EKG □ Other I acknowledge that the data to my signature below authorize I Terms: □ □ I understand that authorizing the treatment. I understand the informatic alcohol abuse treatment, psychiatric c Expiration and Right to Revoke Authorizing the treatment.	be released MAY INCLUDE material that is protect release of the following type of information. de disclosure of the above information is voluntary and I need not on in my health record may include records relating to sexually are or other sensitive information. Derization: has already been taken in reliance on this authorization, at any earles office. Unless revoked earlier, this authorization will explanation.	time I may revoke this authorization by		
□ Immunization Chart □ EKG □ Other I acknowledge that the data to my signature below authorize I Terms: □ I understand that authorizing the treatment. I understand the informatical cohol abuse treatment, psychiatric concepts in Except to the extent that action I submitting a notice in writing to Dr. Sewas signed, or upon the following date Re-Disclosure:	be released MAY INCLUDE material that is protect release of the following type of information. de disclosure of the above information is voluntary and I need not on in my health record may include records relating to sexually are or other sensitive information. Derization: has already been taken in reliance on this authorization, at any earles office. Unless revoked earlier, this authorization will explanation.	ted by Federal Law. My initials and on sign this form to ensure transmitted diseases, drug and/or time I may revoke this authorization by ire six months from the date on which it		
□ Immunization Chart □ EKG □ Other I acknowledge that the data to my signature below authorize in the signature below authorize in the treatment. I understand the information alcohol abuse treatment, psychiatric consideration and Right to Revoke Authorize in Except to the extent that action I submitting a notice in writing to Dr. Se was signed, or upon the following date Re-Disclosure: □ I understand that once the above	be released MAY INCLUDE material that is protect release of the following type of information. e disclosure of the above information is voluntary and I need not on in my health record may include records relating to sexually are or other sensitive information. brization: has already been taken in reliance on this authorization, at any earles office. Unless revoked earlier, this authorization will experte or event:	ted by Federal Law. My initials and on sign this form to ensure transmitted diseases, drug and/or time I may revoke this authorization by ire six months from the date on which it		

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