HARBIR MAKIN, M.D. 3300 PROVIDENCE DRIVE SUITE 114 ANCHORAGE ALASKA 99508
907-770-6200 Fax: 907-770-6202

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

PATIENT NAME_____ DATE OF BIRTH _____

DAY PHONE _____Email:_____ SOCIAL SECURITY # _____

I Authorize: _____To Disclose to: _____

_____

By initialing the spaces below I specifically authorize the release of the following medical records, if such exist by fax or mail.

Release the following information:

_____ Office notes

_____ Laboratory reports

_____ X-ray reports

_____ EKG reports/Holter/echo

_____ Complete records

_____ Other (specify)_____

For the purpose of:

_____ Continuing care

_____ Transfer of care

_____ Insurance purposes

_____ Worker's compensation

_____ Attorney/court case

_____ Other (specify)_____

_____ HIV/Aids related records (must be initialed to be included in other documents)

_____ Mental health information (must be initialed to be included in other documents)

_____ Drug/alcohol diagnosis, treatment or referral information.

I understand I have the right to revoke this authorization at any time and must do so in writing and this does not apply to the information which has already been released as a result of this authorization. I understand that this revocation will not apply to my insurance companies and payors when the law provides my insurer with the right to contest a claim or process a claim under my policy. Unless otherwise revoked this authorization will expire on _____. If I fail to specify an expiration date, this authorization will expire 90 days from the date it was signed. I understand that disclosure of health information is voluntary and 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 of an unauthorized re-disclosure and may no longer be protected by the federal confidentiality laws. If I have any questions about this disclosure I can contact Dr. Makin at 261-3171 or 770-6200.

I understand that the first copy of my records for the purpose of continuing care/or transfer of care is given free of charge. For any additional copies there will be a charge of $55.00 or more depending on the volume of the chart.
For legal request there is always a charge depending on the volume of the chart.

PATIENT/LEGAL GUARDIAN SIGNATURE_____ DATE _____

WITNESS _____ DATE _____

FOR OFFICE USE ONLY

NAME OF EMPLOYEE who processed the request _____ Date request processed _____