



# Imaging Center

PLACE PATIENT ID LABEL HERE

## AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Notice: This request is not valid unless all requested information is provided

Release From:	Name: Providence Imaging Center	Phone: 907-212-3151, Option 7
	Address: 3340 Providence Drive, Suite 101, Anchorage, AK 99508	
Release To:	Name:	Phone:
	Address:	

### Patient Identification:

Patient Name:	Date of Birth:
Address:	Telephone #:

**Information To Be Released (Please be specific):**  
 From (date): \_\_\_\_\_ To (date): \_\_\_\_\_ Or information pertaining to: \_\_\_\_\_

**Please check type of information to be released:**

<input type="checkbox"/> Imaging Reports	<input type="checkbox"/> Complete Imaging Medical Record
<input type="checkbox"/> Imaging-Based Path Reports	<input type="checkbox"/> CD Images
<input type="checkbox"/> Other (specify): _____	

**Receive by:**

<input type="checkbox"/> Mail	<input type="checkbox"/> E-Mail _____
<input type="checkbox"/> Pick-up	<input type="checkbox"/> Fax (Reports only) _____ <input type="checkbox"/> Digital Push

**Purpose of Request:**

<input type="checkbox"/> Personal (at the request of the patient)	<input type="checkbox"/> Legal	<input type="checkbox"/> Government
<input type="checkbox"/> Treatment	<input type="checkbox"/> Insurance	<input type="checkbox"/> Other (specify): _____

**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 that 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 & 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 the Health Information Services Department. 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 If signed by legal representative, relationship to patient: \_\_\_\_\_

### When form is complete:

1. Download form
2. Save form
3. Delivery options (choose one):
  - a. Email form to [pic.fileroom@providence.org](mailto:pic.fileroom@providence.org)
  - b. Fax form to 907-212-3119
  - c. Mail or hand deliver to 3340 Providence Drive, Suite 101, Anchorage, AK 99508

3340 Providence Drive, Suite 101  
 Anchorage, AK 99508  
 Phone: 907-212-3151, Option 7  
 Fax: 907-212-3119  
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