# RELEASE/REQUEST OF MEDICAL INFORMATION

*(All lines must be completed before the records can be released.)*

I, _____, hereby authorize the release of the following information:

***(Please specify only information required, not "All Records".)***

To include records dated from _____ to _____

☐ Gyn/PAP records (past ____ yrs)
☐ Immunization/pediatric records
☐ Last Three Visits
☐ Medication Lists
☐ Drug/alcohol/STD/HIV/mental health info **
☐ Information related to specific problem:_____
☐ E.R report - date:_____
☐ Lab/x-ray reports - date:_____
☐ Neurodiagnostic testing - date:_____
☐ Other: _____
_____
_____

The requested information is released/requested for the following purpose and for that purpose only:

☐ Ongoing treatment ☐ Insurance requested* ☐ Personal* ☐ Legal/Admin* ☐ Other:_____

Please circle from or to below:

From/To: **Family Life Matters, LLC**
16720 E. Maud Rd. Palmer, AK 99645
Ph 907 631-3684 Fax 907 707-1212

To/From: _____
*(Name of Hospital, Clinic or Doctor)*

_____
*(Address)*

_____
*(City, State, Zip)*

☐ **MUTUAL** exchange of information: *(Be specific, please)*
Information needed now: _____
Information to be sent to us: _____
Information for future use: _____

PATIENT'S IDENTIFYING INFORMATION:

Name of patient at time of treatment:

Birthdate: Social Security Number:

Address at time of treatment:

*** Fees for Copying Records to release from Family Life Matters, LLC**

*Personal Request:* One-time courtesy copy of current records up to 10 pages = No Charge; all copies after that are charged 1st 25 pages = $25 , each additional page = $.50 cents/page.

*Insurance/Administrative Request*: 1st 50 pages = $50, each additional page = $.50 cents/page.

*Provider Request:* Copies of records required for specified ongoing care = No Charge; request for copies of all records with out regard to specific illness or time frame: 1st 25 pages = $25, each additional page = $.50 cents/page.

*Legal Request*: 1st 50 pages = $65 each additional page = $.60 cents/page.

Signed: _____ Date: _____
(patient, parent, or legal guardian)

Witness: _____

*This consent will expire on _____ or 60 days after the date above.*

Received by Family Life Matters, LLC on _____ by _____

** I acknowledge that data marked with ** may include materials that are protected by Federal law. My signature above authorizes the release of this information. This consent is subject to revocation at any time except to the extent that the department, which is to make the disclosure, has already taken action in reliance on it. You may obtain a revocation form at the office or write a letter to the office.

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Hipaa Compliant/