Owen R. Bell, MD

Martha Linden, CNM, APRN

Authorization to Release Healthcare Information

Patients Name:_____**Date of Birth:**_____

Other Names:_____

Please select To/From

Release: ☐ **From** ☐ **To**

Owen R. Bell, MD

2501 E 42nd Ave

Anchorage, AK 99508

*Requesting Provider*_____

Ph: 907-561-1925

Fax: 907-561-1429

Please select To/From

Release: ☐ **From** ☐ **To (please list)**

Name:_____

Organization:_____

Address:_____

City,State,Zip:_____

Phone:_____

Fax:_____

Information requested (REQUIRED) ***IF THERE IS MORE THAN 40 PAGES PLEASE MAIL***

☐ *Progress Notes* ☐ *Lab/Pathology Reports* ☐ *X-Ray/Diagnostic Reports*

☐ *Operative Reports* ☐ *Current Pregnancy*

☐ *Other:*_____ ***Treatment Date(s):***_____

Purpose of Request (REQUIRED)

☐ *Patient Request* ☐ *Continuous of Care* ☐ *Termination of Care*

☐ *Insurance Request* ☐ *Open Communication* ☐ *Other*_____

Please Initial

_____I authorize the release of any records regarding drug, alcohol, and psychiatric or mental health treatment to the person(s) or organization listed above.

_____I understand that this authorization is voluntary, that I can revoke my authorization at any time by notifying the individual(s) or organization releasing this information in writing, and that if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information will not condition my treatment, payment, enrollment in a health plan or eligibility of benefits on whether I provide this authorization. This form is good for 1 year from date of signing.

_____ I understand that my records may contain sensitive information, if the person(s) or organization authorized to receive this information is not a health care provider, the information released may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep it confidential.

_____I understand that the first copy of my records for the purpose of continuing care/or transfer is given free of charge. Any additional copies there will be a charge of $50.00

Signature:_____Date:_____