ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

3831 Piper Street Suite S450 Anchorage, AK 99508 Phone 907-258-6999 Fax 907-258-6247

PATIENT ACCESS TO THE MEDICAL RECORD REQUEST FORM

To release the personal health information of:

(Print) Patient Name: ______________________________ Date of Birth: __________ SSN: ____________

Address: ____________________________________ City: ______________ State: _____ Zip:_______

Home phone: __________________ Cell phone: ____________________ Fax: ____________

I authorize Anchorage Neurosurgical Associates, Inc. ("ANAI"), to make copies of my medical records for my personal inspection. I understand that these records contain protected health information. I agree to pay a fee for the cost of copying the records, at **$0.25 per page**, and for any mailing costs.

Release the following information:

☐ Progress Notes/Treatment Plan ☐ Op Report(s) ☐ Consultation(s)
☐ X-ray/Radiology Report(s) ☐ Laboratory/Pathology Report(s) ☐ Itemized Billing
☐ Other: ____ ☐ Entire Medical Record

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Reason for this Request:

☐ At my request ☐ Other: ____

Expiration Date of Request: This authorization will remain in effect for one (1) year, unless I have checked or filled in a different expiration date. ☐ None ☐ Other: ____

____ **PICK UP.** I agree to pick the records at ANAI and request the records be released to myself or my personal representative/guardian, whose name is: ______________________________________ (Print).

Note: ANAI reserves the right to request personal identification be presented by persons who may be designated to receive Protected Health Information on behalf of the patient.

____ **MAILING**. I understand there will be a charge for handling and postage for this service. I request the medical records to be mailed to the following address:
(Print) Address: ________________________________ City:____________ State: _____ Zip:________

I understand that:

- After the custodian of records discloses my health information, it may no longer be protected by federal privacy laws.
- I have 4 weeks to pick up records once made available. After that time they will be destroyed and a new request must be submitted.
- I further understand that this Authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
- I have the right to revoke this authorization in writing at any time.

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

I have read and understand the terms of this Authorization, and I hereby knowingly and voluntarily authorize ANAI to disclose my health care information in the manner described above.

____ Date: ______________________
Signature of Patient or Legal Representative

____
If signed by Legal Representative, relationship to patient

FOR OFFICE USE ONLY

INTAKE BY: ___________ PROCESSED BY: ___________ FEE: $___________

RECORDS WERE: ☐ MAILED ☐ TO BE PICKED-UP ☐ FAXED