AMERICAN HYPERBARIC CENTER

2710 Wesleyan Drive, Suite 201
Anchorage, AK 99508
Phone (907) 565-4600
Fax (907) 565-4605

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information: MR#_____

*Patient Name:_____

*Date of Birth: _____

I authorize the custodian of records_____ or another person/entity (specifically describe)_____to disclose /release the following information* (check all applicable)

____All Records
____Laboratory/Pathology Records
____Xray/Radiology Records
____Billing Records
____Abstract/Summary
____Pharmacy/Prescription Records
____Other (describe specifically)
_____

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

These records are for services provided on the following date(s):_____
Please send the records listed above to:

American Hyperbaric Center 2710 Wesleyan Drive #201 Anchorage, AK 99508
Phone: (907)565-4600 Fax: (907)565-4605

_____ Mail _____Fax

This authorization shall expire no later than ___/___/___ or upon the following event

_____ (whichever is sooner), and may not be valid for greater than one year from the date of the signature.

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to American Hyperbaric Center, a Division of American Marine Services Group. Unless revoked earlier, this authorization will expire 180 days from the date of signing. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

_____ _____
Signature of patient (or Patient's Legal Representative) Date

_____ _____
Printed Name of Patient or Representative Relationship of Legal Representative to Patient