Juneau
OBSTETRICS & GYNECOLOGY

3268 Hospital Drive, Suite B
Juneau, AK 99801
(P) 907-586-1717
(F) 907-586-2677

Authorization for Release of Personal Health Information

Today's Date: _____

Patient Name _____ DOB: _____

Dates of Service: _____

Records Requested: _____

I hereby authorize: _____

_____

_____

Fax #: _____

To furnish, in full detail, information regarding my medical care and the information contained within my medical record. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by:

Juneau Obstetrics and Gynecology
3268 Hospital Dr, Suite B
Juneau, AK 99801
Phone: (907) 586-1717
Fax: (907) 586-2677

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signed: _____ Date: _____

Relationship: _____

Witness: _____ Date: _____