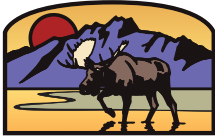

MOOSE CREEK
Medical Clinic, LLC
211 E. Fairview Loop
Wasilla, Alaska 99654
www.MooseCreekMedical.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:______________________________ DOB:______________

Social Security Number:______________ Phone (home):____________ Phone (cell):____________

Address:____

City, State, Zip:__________________________________

The above listed patient authorizes the following healthcare facility to make record disclosure:

To/From:

Moose Creek Medical Clinic LLC

211 E. Fairview Loop

Wasilla, Alaska 99654

Phone: (907) 373-3335

Fax: (907) 373-3331

To/From:

Facility Name:______________________________

Facility Address:______________________________

City/State/Zip:______________________________

Phone:______________________________

Fax:______________________________

The purpose of the disclosure is:

- ☐ Ongoing Medical Treatment
- ☐ Personal/Legal/Administration
- ☐ Insurance Request
- ☐ Other

Information to be released:

- ☐ Medical Records
- ☐ Hospital records from the following dates: start________ finish ________
- ☐ Labwork
- ☐ Radiology Results

Restrictions: Only medical records generated in this healthcare facility will be copied unless otherwise requested. This authorization is only valid for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand I may revoke this authorization at any time. 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. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand the Chemical Dependency clients/patients records are protected by Federal Law (42CFR, part 2) and can not be disclosed without this written consent unless otherwise provided in federal regulations.

If I have questions about disclosure of my health information, I may contact Moose Creek Medical Clinic LLC.

I have read the above Authorization fro Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

I understand that there will be a fee assessed with copying records. (see below)

This authorization shall remain in effect for 1 year following the date signed. A photocopy is as valid as the original.

Signature of Patient/Parent/Guardian/Authorized Representative:______________________ Date:__________

Printed Name of Authorized Representative:______________________________

Relationship/Capacity to Patient:______________________________

Fees for Record Copying:

Personal Request: No charge for a one time courtesy copy of current records up to 25 pages.
Insurance/Administration: First 50 pages, $50, each additional page $0.50.
Provider Request: No charge for copies of records required for specified ongoing care.
Requests for copies of all records without regard to specific illness or time frame, first 25 pages, $25.
Legal Request: First 50 pages, $65.00, then each additional page $0.60.