



9500 Independence Drive, Suite 700, Anchorage, AK 99507

AUTHORIZATION FORM

I _____ authorize Algone Anchorage to verbally discuss my medical records with:

1.

2.

3.

4.

5.

6.

By signing this authorization form, I understand that:

- This is not an authorization to release printed medical records.
- Some records may contain extremely confidential information. This may include alcohol/substance abuse/testing, mental health conditions/psychotherapy notes and psychological evaluations, HIV testing, status or care and treatment for AIDS, sexually transmitted disease/testing, and genetic records.
- Once the office discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.
- I may revoke this authorization in writing. If revoked, it would not affect any actions already taken by Algone Anchorage based upon this authorization. Two ways to revoke this authorization are: Fill out a revocation form (available from the office) or write a letter to the office.

Patient Name:

Date of Birth:

Patient or Parent/Guardian Signature

Date