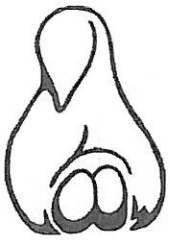

INTERIOR WOMEN'S HEALTH, LLC
1626 30th Avenue
Fairbanks, AK 99701-7423
907-479-7701 (phone)
907-479-7718 (fax)
e-mail: iwh@acsalaska.net
www.interiorwomenshealth.com

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: _____

Maiden Name/Other Names: _____

Phone Number: _____ SSN# (optional): _____

Note: Dear Patient first 10-pages are at a courtesy NO CHARGE; however, for any additional pages, an administrative cost of $.15 cents per page will be charged.

I hereby authorize Interior Women's Health, LLC to:
_____ **RELEASE** Information to: **OR** To _____ **OBTAIN** Information From:

Person OR Agency/Clinic/Insurance Company/ Other:

_____

Address: _____

City, State, Zip: _____

Phone # _____ Fax #_____

IMPORTANT: DATES OF TREATMENT PLEASE

Purpose of Information Requested:
_____Second Opinion
_____Continued Treatment
_____Personal Use
_____Legal Use
_____Employment
_____Other (please specify)
_____
_____

Dates of Treatment Requested:_____
Information Requested: *(Please Circle Y or N for each item)*
Verbal Information Y N
Lab Reports Y N
Progress Notes Y N
Radiology Reports Y N
Other (please specify) _____
Dates of Treatment from:_____ to:_____

I understand that my medical record may include sensitive information including but not limited to the diagnosis and treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), HIV status and/or STD's. I understand and agree that the information, if any pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES: *(you must initial one)*

I Do_____ I Do Not_____ Authorize this information to be released.

Release Limitations, if any: _____

The above information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the released of medical information and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

* I may refuse to sign this authorization form. Interior Women's Health, LLC will not condition or deny treatment on my signing this authorization.

DURATION	This consent will expire **one (1) year from the date of signature** unless otherwise specified. I also understand that this authorization can be revoked in writing at any time except to the extent that action has been taken in reliance of this authorization.
REVOCATION	I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this signed authorization by notifying Interior Women's Health, LLC in writing or by filing out a Revocation of Authorization Form
REDISCLOSURE	When your medical information is released pursuant to a valid authorization you should be aware of the following: That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

TREATMENT MAY NOT be withheld or conditioned on obtaining authorization.

_____ _____

Signature of Patient/Legal Representative Date

_____ _____

Relationship to Patient Date

_____

Expiration Date
(1-Year from above date)

A copy of this form will be made available to the patient upon written or verbal request.

FOR IWH'S OFFICE USE ONLY	
IWH eRecord #:_____	Date Completed:_____
Request Processed by:_____	Request Completed By:_____
Date Needed:_____	
Pick up Fax Mail *(circle one)*	**Pick up Fax Mail *(circle one)***