Print Form

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

NorthStar RADIOLOGY

Medical Record # _____

Patient's name: _____ Date of birth: _____

SSN: _____ Previous Name: _____

I request and authorize _____ to release health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: AK _____ Zip Code: _____

For the purpose of: _____

This request and authorization applies to:

☐ Health Care information relating to the following treatment, condition or dates of treatment

_____

☐ All Health Care Information _____

☐ Other _____

By initialing the spaces below, I specifically authorize the release of the following records, if such records exist: (Please initial all that may apply)

_____ HIV (Aids Virus)* _____ Sexually Transmitted Diseases*

_____ Mental Health* _____ Drug and/or alcohol use*

* If a minor consented to health care without parental consent for his/her own treatments, then the minor must consent or release of health care information.NSR is hereby released from all legal responsibility or liability for the release of the above-mentioned information. Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information. You are entitled to a copy of the authorization. You may revoke this authorization by a written request. If you have any questions about disclosure of your health information, you may contact the Release of Information desk in the HIM department at

_____ _____

X Signature of patient Date

_____ _____ _____

X Signature of guardian or authorized person to consent for this patient Date *Relation to patient

I.D. type verified: _____ Released by (initials): _____

NSR will provide complimentary copies of your health care information to your physician.
All other requests are subject to a fee. Please inquire about charges.
Authorization becomes invalid ninety (90) days after it was signed,
or upon the expiration date _____, whichever is earlier.