PIONEER PEAK
ORTHOPEDIC SURGERY

Charles Haggerty, MD
Michael Montano, MD
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Medical Record Release Authorization

Full Name: _____ **DOB:** _____

Address: _____

Cell: _____ **Home Phone:** _____ **Last 4 of SSN:** _____

I hereby authorize records FROM:

Name: Pioneer Peak Orthopedic

Address: 3765 E Blue Lupine Dr Suite D

City, State, & Zip: Wasilla, AK 99654

PH: 907-707-1671 FX: 907-707-1675

I hereby authorize records TO:

Name: _____

Address: _____

City, State, & Zip: _____

PH: _____ FX: _____

Record Dates From: _____ To: _____

Type Records Requested:

☐ All Records ☐ Operative/Procedure Reports
☐ Records regarding _____
☐ X-Ray/MRI/CT/ Radiology Reports & Images
☐ Other: _____

Send Via:
☐ Mail ☐ Fax ☐ To be picked up by: _____

For the purpose of:

☐ Transfer or Continuance of Care
☐ Personal Copy
☐ Insurance
☐ Disability/Litigation
☐ Other: _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical 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. I understand that I have a right to 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 Medical Records Department. 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 have read the information provided on this release form and do hereby acknowledge that I understand the terms and conditions of this authorization.

_____ _____
Signature of Patient/Parent/Guardian/Authorized Representative *Date*

This authorization will expire one year from the above date unless I specify an expiration date: _____

Please note that you may be subject to fees – all 24 hour expedited request will have a $10 upcharge.