ALASKA DIGESTIVE & LIVER DISEASE
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Consent to Release and Disclose Protected Health Information

I, _____ the patient, D.O.B _____ Phone #_____ Hereby Authorize: _____

To release my health information as identified below for the following purpose(s):

____ Continuation of Care ____ Other: _____
____ Second Opinion ____ Personal Use

Information to be disclosed

Please check all appropriate boxes:

____ Summary of Medical History/ Treatment
____ Laboratory/ Diagnostic Tests
____ Radiology Records
____ All records, including any records in these subject areas:
- _____ HIV/ AIDS
- _____ Sexually transmitted disease
- _____ Mental illness or mental health treatment
- _____ Drug and alcohol abuse/ treatment

____ Other _____

Person/ Organizations TO Receive Information

Name of persons/ Organizations	Complete Address/ Phone

The staff may discuss my medical condition and treatment with those persons listed above. This consent is subject to revocation at any time except to the extent that the persons/organization which is to make the disclosure has already taken action in reliance on it.

Re-Disclosure Prohibited: This information has been disclosed from records whose confidentiality's protected by state or federal law (42CFR part 2). These laws prohibit making any further disclosure of this information without the specific written consent of the person whom it pertains, or as otherwise permitted by law.

I understand I may revoke this consent at any time. This consent expires on _____ or in 180 days unless otherwise specified.

Signature Date

Witness/ Title Date