□ John B. DeKeyser, M.D., P.C.
1200 Airport Heights Dr. #280
Anchorage, AK 99508
Phone (907) 339-9717
FAX (907) 339-9720

□ John D. Erkmann, M.D., P.C.
1200 Airport Heights Dr., #280
Anchorage, AK 99508
Phone (907) 339-9700
FAX (907) 339-9720

RELEASE OF MEDICAL INFORMATION (TO OR FROM THIS OFFICE)

Patient Name: ______________________________ Previous Name(s): ______________________________
DOB: ___________________ SSN (optional): _______________________

I authorize the use and/or disclosure of my health information as identified below. One copy will be provided to the patient at no charge, subsequent copies will be charged. Please release a copy of my health information (medical records) to:

□ John B. DeKeyser, MD, 1200 Airport Hgts Dr. #280, Anchorage, AK 99508
□ John D. Erkmann, MD, 1200 Airport Hgts. Dr. #280, Anchorage, AK 99508
□ Other, Name ____
Address ____
Phone _______________________ FAX ________________________

Information to be Disclosed:

□ Complete Medical Records
□ Laboratory & Pathology Reports
□ Obstetric Records
□ Other ____
□ Most recent 5 yr. history
□ Clinical Office Notes
□ Specific Date of Service ______________

*The following items **must** be initialed to be included in the use or disclosure:*
_____ □ HIV/AIDS related information/or records
_____ □ Mental/Behavioral health information or records
_____ □ Genetic Testing information or records
_____ □ Drug/Alcohol diagnosis, treatment, &/or referral information
_____ □ Sexually Transmitted Disease information/or records

For Tracking purposes please check all boxes that apply:
□ Leaving the state or Anchorage area
□ Personal Reasons, staying with clinic
□ Referred here, returning to original provider
□ Coordination of Care between providers
□ Other, *Specify*____
□ Seeking Second Opinion
□ Transferring to another provider
□ Provider/Staff Problems
□ Financial Reasons

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the Practice Manager. Unless revoked earlier, this authorization will **expire 180 days** from the date of signing. *Insert date* ______________

I also understand that if, the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

I understand that I can receive one free of charge copy of my medical records.

____ ________________
Signature of Individual or Legal Representative Date

____ ________________
Printed Name of Legal Representative (if applicable) Relationship to Individual