Forget Me Not
HEALTHCARE CLINIC
9500 Independence Dr., Suite 1000, Anchorage, AK 99507 | 907-339-7272 *(M)* 907-339-7273 *(F)* | info@FMNHC.com

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____Birth Date: _____

Other Names Used: _____

I authorize __Clinician/Clinic Name_____Clinic Address_____Clinic Fax #__
to send requested patient records to: ***Forget Me Not Healthcare Clinic***
9500 Independence Drive, Suite 1000, Anchorage, AK 99507. Fax: 907-339-7273

I would like the follow records to be sent:

ALL Records _____ **Specific Records dated _____to_____**

Records related to _____

Specific Sensitive Information needs to be initiated to be disclosed:

_____ Mental/Behavioral Health Treatment _____ Drug/Alcohol Abuse _____ HIV/AIDS _____ STD

Valid dates of record request:
Expiration: This authorization will expire one (1) year from the signature date, unless an alternative expiration date is provided here: ___/___/___
Revocation: An authorization may be revoked at any time by written notice to Forget Me Not Healthcare Clinic (FMNHC). Revocation is not effective until notice is received and is not effective regarding disclosures made before revocation and where authorization was obtained as a condition of insurance coverage.

Patient Rights:
I understand that: (1) I have a right to receive a copy of this signed authorization upon request; (2) I have a right to refuse sign this authorization. FMNHC may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on a decision to sign this form; and (3) I have a right to inspect or copy my health information. I may arrange to inspect or copy information maintained by FMNHC. I may be charged a reasonable fee for copying costs.

I authorize the disclosure of health information described above. Information released under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. A photo copy/fax of this form is as valid as the original.

Signature: _____Date: _____
Print Name: _____
Preferred contact for any questions? Phone: _____Email: _____

OFFICE USE ONLY: Date Received _____