Anchorage Neurosurgical
ASSOCIATES INC.
BRAIN | SPINE | NERVES | EST. 1981

ANCHORAGE NEUROSURGICAL ASSOCIATES, INC.

PATIENT ACCESS TO THE MEDICAL RECORD REQUEST FORM

To release the personal information of:

(Print) Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Fax: _____

I authorize Anchorage Neurosurgical Associates, Inc. ("ANAI"), to make copies of my medical records for my personal inspection. I understand that these records contain protected health care information.

Release the following information:

☐ Progress Notes/Treatment Plan ☐ Op Report(s) ☐ Consultation(s)
☐ X-ray/Radiology Report(s) ☐ Laboratory/Pathology Report(s) ☐ Itemized Billing
☐ Other: _____ ☐ Entire Medical Record

**Note: You are hereby authorizing disclosure of all information in the items you have checked above, including information from previous providers and information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse or sexually transmitted disease contained in the items checked above.*

Reason for this Request:

☐ At my request ☐ Other: _____

Expiration Date of Request: This authorization will remain in effect for one (1) year, unless I have checked or filled in a different expiration date. ☐ None ☐ Other _____

☐ PICK UP:. I agree to pick up the records at ANAI and request the records be released to myself or my personal representative/guardian, whose name is: _____ (Print).

Note: ANAI reserves the right to request personal identification to be presented by persons who may be designated to receive Protected Health Information on behalf of the patient.

☐ MAILING.

Address: _____ City: _____ State: _____ Zip: _____

I understand that:

- After the custodian of records discloses my Protected Health Information, it may no longer be protected by federal privacy laws.

(Continued on next page…)

- I further understand that this Authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
- I have the right to revoke this authorization in writing at any time.
- I have 4 weeks to pick up records once made available. After that time they will be destroyed and a new request must be submitted.
- My COMPLETE medical record is provided free of charge **for the first request.** Any later requests for my COMPLETE medical record will be provided for a fee. This does NOT include PARTIAL record requests (i.e. requesting my most recent chart note and related reports).

By signing below I represent and warrant that I have authority to sign this document and to authorize the use or disclosure of Protected Health Information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use or disclosure of this Protected Health Information.

_____ _____

Signature of Patient or Legal Representative Date

_____

If signed by Legal Representative, relationship to patient

FOR OFFICE USE ONLY

INTAKE BY: _____ PROCESSED BY: _____

RECORDS WERE: ☐ MAILED ☐ FAXED