AUTHORIZATION FOR RELEASE OF INFORMATION

Mary Ann Jacob M.D., LLC
2841 DeBarr Rd., Suite. 45
Anchorage, AK 99508
Phone: 907-274-0274 Fax:907-274-7809

Patient Name:_____**DOB**_____

I hereby authorize Mary Ann Jacob M.D., her authorized employees or agents to:

☐obtain information indicated below from: or
☐release information indicated below to:

Name:_____ Phone and /or Fax:_____

Address:_____

I authorize the release of only that information checked below:(note: specific release for mental illness, drug/alcohol abuse, and HIV/AIDS is required below)

☐**All Records** including all areas listed below or **only those checked below**
☐Summary (Problem List, Medications, Allergies)
☐Office Notes
☐Consult Reports
☐Lab Work
☐X-Ray Reports
☐Other:_____

I understand that this information may relate to diagnosis and treatment of physical and/or mental health. If this information relates to mental illness, drug and alcohol abuse and/or HIV/AIDS, I understand that I must specifically authorize Dr. Mary Ann Jacob to disclose this information for any purpose, with limited exceptions, such as in emergencies or as required by law.

I specifically authorize the release of information that references:

☐ Mental Illness
☐ Drug/Alcohol Abuse
☐ HIV/AIDS

Purpose of release (check all that apply):

☐ Transfer of Care
☐ Coordination of Care
☐ Personal Reasons ($10 + .35/page)
☐ Other: _____

I have read this form, including the information on page 2 (back of page) and I wish to have the designated health care information released. I will not hold Dr. Mary Ann Jacob responsible for any misuse of this information that may occur.

_____ / / /

Signature of Patient/Parent/Guardian Printed Name Date

_____

Relationship and authority to sign, if signed by other than patient.

I understand that I may refuse authorization to disclose all or some health care information. However, refusal may result in improper diagnosis and treatment, denial of coverage or a claim of health benefits or other insurance, or other adverse consequences. Partial or incomplete records will be labeled as such.

This authorization will expire 12 months from the date signed unless I revoke it; I understand that I can revoke this authorization at any time by notifying Dr. Mary Ann Jacob's office in writing pursuant to Dr. Jacob's notice of privacy practices.

I understand that my health care records are the property of Dr. Mary Ann Jacob, and that I or other recipients will receive a copy of them on request. I also understand that I may be asked to show a picture containing identification, such as a driver's license, to insure confidentiality.

I understand that I have the right, subject to certain conditions, to:

- Request restrictions on certain uses and disclosures of facts about me upon request. However, Dr. Mary Ann Jacob is not required to agree to the requested restrictions.
- Receive confidential communication of my protected health data by giving us another address or means of receiving health data.
- Inspect and copy my protected health data upon request (unless the contents are deemed dangerous to the patient or others).
- Append information to my protected health data upon request.
- Receive a list of releases made of my protected health data upon request.
- Obtain a paper copy of this notice upon request, if I agreed to receive this notice by e-mail, fax, or website.

I understand I have the right to receive a signed copy of this release. I understand that once information leaves Dr. Jacob's office, further releases by the receiving party may no longer be protected by law.

If I am under 18 years old, I understand that my parent/guardian must sign this form, except under certain circumstances, such as where I have consented to my healthcare or am married.

I have read this form and I wish to have the designated health care information released. I will not hold Dr. Mary Ann Jacob responsible for any misuse of this information that may occur.