

# Hillside Family Medicine, LLC

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## AUTHORIZATION TO RELEASE INFORMATION\*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Contact Phone number: \_\_\_\_\_

I request and authorize:

Hillside Family Medicine, LLC  
9220 Lake Otis Pkwy, Suite 9  
Anchorage, Alaska 99507  
Phone: (907)344-0200 Fax: (907) 344-0218

to process the following request in regards to my medical records:

SEND  OBTAIN

My medical records **from/to** the following Provider:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone\*: \_\_\_\_\_ Fax: \_\_\_\_\_  
*\*information **REQUIRED** to complete request!!!*

I **AUTHORIZE** the following information to be disclosed: (Please **check** all that apply)

- Entire Chart
- X-Rays
- Billing Records
- Other: \_\_\_\_\_

Additional Information: \_\_\_\_\_

This authorization expires on \_\_\_\_\_ or, 90 days from the date of signature. I understand I have the right to revoke this consent any time in writing except to the extent that the information has already been released.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*\*Section 164.506 © (1) of the HIPAA Privacy Regulation states a covered entity is not required to obtain a patient authorization to use or disclose patient health information for treatment, payment, or its own health care operations.*

**HIV ONLY:** I understand specific reference may be made to HIV testing and results, and any related diagnosis and medical condition(s) which may be recorded in my health records. I hereby authorize the release of any HIV antibody test results and related information. Exchange of information ensures continuity of care between providers. By not sharing information my health care could be compromised. Only that information which I authorize will be released.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date