Pioneer GI Clinic, APC
1200 Airport Heights Drive Suite 210
Anchorage, AK 99508

Phone 907-562-6001
Fax 907 562-6002
office@pioneergiclinic.com

www.pioneergiclinic.com

Authorization for Use/Release of Health Information

Name: _____ Phone: _____ DOB: _____/_____/_____

I hereby authorize Pioneer GI Clinic to obtain information from:

Person/Agency: _____

Address _____City: _____State: _____ ZIP: _____

Phone: _____ Fax: _____

I hereby authorize Pioneer GI Clinic to release information to:

Person/Agency: _____

Address _____City: _____State: _____ ZIP: _____

Phone: _____ Fax: _____

Types of Records:

Date Range ◯ from: _____ to: _____ ◯ all records

- ☐ Chart Notes
- ☐ Labs/Pathology
- ☐ Imaging/X-Rays
- ☐ Demographic Information
- ☐ Hospital Records
- ☐ Procedure Reports

Following Sensitive Information Requires Initials to Release

_____ HIV/HCV/AIDS/Sexually Transmitted Information

_____ Mental Health Information or Records

_____ Drug/Alcohol Diagnosis, treatment and/or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law Prohibits re-disclosure of such information

I understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal regulation.

Patient or Legal Representative Signature: _____ Date: _____
Witness: _____ Date: _____