Geneva Woods Midwifery
2400 E 42nd Avenue
Anchorage, AK 99508-5206

Phone: (907) 561-2626
Records Fax: (844) 831-2350

Name of Patient: _____ Date of Birth: _____

Daytime Phone: _____ Evening Phone: _____ Email: _____

Address: _____

I hereby authorize A Joint Effort Physical Therapy to disclose my protected health information as indicated below to:

□ Geneva Woods Midwifery
2400 E 42nd Ave
Anchorage, AK 99508
Fax: (844) 831-2350
Phone: (907) 561-2626

□ Myself

□ _____
_____
_____
Fax: _____
Phone: _____

If you wish the records to be released to yourself, please indicate the method:

□ Fax: _____ □ Pick up CD in person □ Pick up paper in person

□ Mail CD to home address □ Mail paper to home address □ Encrypted, password-protected email

Information to be released:

□ From & To Dates: _____
□ History & physical exam(s) _____
□ Lab &/or X-ray reports _____
□ Other _____
□ All Records
□ Records from other offices released by signed ROI or sent for TPO

I understand that this health information may include HIV-related information &/or information relating to the diagnosis or treatment of psychiatric disabilities &/or substance abuse and that by signing this form I am specifically authorizing the release of information relating to:

□ Substance abuse
□ Mental Health
□ HIV Related Information, including test results

The confidentiality of this record is required under Title 42 of the United States Code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

_____ _____
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Privacy Officer at the address listed at the top of this form, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ OR _____ _____
Signature of Patient Parent/Legal Guardian/Authorized Person Date

For office use only:

Date Request Received: _____ Date Request Filled: _____ Method of Transmission_____