ALASKA UROLOGY

PATIENT REQUEST TO ACCESS PERSONAL HEALTH INFORMATION

To access or obtain a copy of your patient records, please complete and return this form to:

Alaska Urology
3841 Piper Street, Suite T300 Anchorage, AK 99508
2925 DeBarr Road, Suite 250 Anchorage, AK 99508
Fax:(907) 561-1862 e mail: info@alaskaurology.com

We may charge you a reasonable fee for copies of your records. We will require payment before providing the copies. Please contact us if you would like to obtain an estimate of the cost of the copies in advance.

**** To be completed by patient or personal representative:***

Date of records request: _____/_____/_____

Patient: _____ **Date of Birth**: ____/____/____
Address: _____
_____

What are the date(s) of treatment for which you would like records?
☐ Treatment provided between ____/____/____ to ____/____/____.
☐ Treatment provided at anytime.
☐ Other:_____

What type of records would you like to obtain?
☐ Medical records (*please specify*)
- ☐ History and physical, exam notes, progress notes, etc.
- ☐ Consultation reports.
- ☐ Operative, surgical, and procedure reports.
- ☐ Laboratory, pathology, and other test results.
- ☐ Diagnostic, images, films, or other recordings (e.g., x-rays, MRI scans, CT scans, photos, etc.)
- ☐ Other: _____

☐ Billing and payment records.
☐ Electronic copy of records identified above (identify requested format).
☐ Other: _____

How would you like to receive the records?
☐ Patient will pick up copies of records from the PROVIDER.
☐ Mail with a pre-payment of $6.65 to the following address: _____
_____
_____

☐ Send the records electronically to the following email address (please note e-mail is unsecure):
_____
☐ Other: _____

I certify that I am the patient identified above or that I am the person with legal authority to make health care decisions for the patient identified above.
Name: _____ Date: ____/____/____
Signature: _____
Telephone: _____

If personal representative, describe relationship to patient or authority:
_____

_____