



Pursuant to HIPAA I, _____, hereby request and authorize:
(Patient Name)

Sportsmedicine Fairbanks
Cary S Keller MD, P.C.
751 Old Richardson Hwy, Suite 200
Fairbanks, AK 99701
Phone: 907-451-6561 Fax: 907 451-6564

To release the medical records specified below to: _____

for the purpose of: Second Opinion
 Continued Treatment
 Insurance or Third Party Payment
 Legal Review
 Other, please specify _____

Medical Records Requested:

Reports pertaining to treatment from: (_____) to (_____) _____
Date Date

for (medical diagnosis/condition): _____

X-Rays Labs

All Records (Please read information below regarding "all records" request.)

(Please be advised it is the policy of Sportsmedicine Fairbanks to comply with Federal HIPAA regulatory guidelines with regard to the release of your medical records. If you request "All Records", this means all past medical care records including but not limited to, chart notes, x-ray reports, laboratory reports, imaging reports, results of procedures, surgical procedures and other medical information you have reported to your medical provider/clinic will be included in the release.

Please send records via: Mail Hospital Courier Fax to: _____ (Limited to ___ pages)
 Patient will pick up (Records requested to be sent via Express Fed Ex will include a Fed Ex charge.)

Date medical records needed by: _____ **Request taken by whom?** _____

(Please note...Medical Records Request requires a minimum of 72 hours written notice of request for processing.)

Patient's Full Name: _____

Patient's Mailing Address: _____

Date of Birth: _____ Social Security Number: _____

Telephone Number: Home (____) _____ Cell (____) _____ Work (____) _____

I understand that this authorization for release of medical records is valid for 60 days and that it can be revoked by me anytime prior to the 60 day term with written notice to Sportsmedicine Fairbanks. Please be advised if someone other than patient picks up records, they must be identified as a designated personal representative. Patient or Designated Personal Representative must show valid identification to pick up records. Once these records are copied and released, Sportsmedicine Fairbanks is no longer responsible for the disclosures of private healthcare information which may occur after the records are released from Sportsmedicine Fairbanks.

I understand there will be a charge for copying Medical Records and X-rays unless prohibited by law or contract.

(Signature of Patient) _____ (Date) _____

Relationship if not patient _____
(Signature for minor (or) Designated Personal Representative)

Witness Signature _____ Date: _____

Identification Verified: _____ Type of I.D. _____ Staff Member: _____ Date: _____