1700 E. Bogard Rd. North Fork Bldg. A Ste. #200 Wasilla, AK 99654
(907) 357-2158 Office * (907) 357-5849 Fax
realtimewasilla.com * rtoffice@mtaonline.net

# RELEASE OF PATIENT RECORDS

## Authorization to use and/or disclose HEALTH INFORMATION

| AUTHORIZATION REQUESTING HEALTH INFORMATION ***FROM*** THE FOLLOWING: | | | |
|---|---|---|---|
| NAME: | PHONE: | FAX: | |
| MAILING ADDRESS: | CITY: | STATE: | ZIP: |

| AUTHORIZATION TO DISCLOSE HEALTH INFORMATION ***FOR*** THE FOLLOWING: | |
|---|---|
| PATIENT NAME: | PREVIOUS NAME: |
| DATE OF BIRTH: | SS#: |
| MAILING: | CITY/STATE/ZIP: |

| AUTHORIZATION TO DISCLOSE HEALTH INFORMATION ***TO*** THE FOLLOWING: | | | |
|---|---|---|---|
| NAME: REAL TIME INC | PHONE: 907-357-2158 FAX: 907-357-5849 | | |
| MAILING ADDRESS: 1700 E. BOGARD RD STE. A200 | CITY: WASILLA | STATE: AK | ZIP: 99654 |

SEND BY: ◯ MAIL ◯ PICK-UP ◯ FAX (NUMBER) _____

PLEASE SEND THE FOLLOWING INFORMATION: ◯ ULTRASOUND REPORT ◯ OTHER (PLEASE SPECIFY)

_____

I understand that I have the right to revoke this authorization at any time, by giving written notice to REAL TIME II LLC. I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorizati on.

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 re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state of federal laws and regulations.

I understand this authorization is specifically for information created from services provided BEFORE my date of signature. Information related to services provided AFTER my date of signature will require an updated form. This authorization will expire _____ _____. If expiration date is not entered, this authorization will expire in six (6) months from date of signature.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO PATIENT: _____