AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	PATIENT DATE OF BIRTH:	SSN:
ADDRESS:	PHONE NUMBER:	MAIDEN/OTHER NAMES USED

I AUTHORIZE THOMAS P. SENTER, M.D. TO RELEASE		NAME:
□ COMPLETE MEDICAL RECORD		ADDRESS:
□ PATHOLOGY, LABORATORY RESULTS	TO	PHONE:
□ SPECIFIC PHI FROM SERVICES RENDERED BETWEEN THE DATES OF AND		FAX:
□ OTHER:_____		□ PLEASE FAX THE REQUESTED INFORMATION TO THE ABOVE NUMBER

I AUTHORIZE THOMAS P. SENTER, M.D. TO OBTAIN		NAME:
□ COMPLETE MEDICAL RECORD		ADDRESS:
□ PATHOLOGY, LABORATORY REPORTS	FROM	PHONE:
□ SPECIFIC PHI FROM SERVICES RENDERED BETWEEN THE DATES OF AND		FAX:
□ OTHER:		□ PLEASE FAX THE REQUESTED INFORMATION TO THE ABOVE NUMBER

PURPOSE OF RELEASE:		**THIS AUTHORIZATION SHALL BE INFORCE AND EFFECT UNTIL:**
□ PERSONAL USE		□ A ONE TIME DISCLOSURE
□ LEGAL USE		□ A CONTINUING DISCLOSURE FOR THIS AND ANY FUTURE TREATMENT, FOR A MAXIMUM OF TWELVE MONTHS.
□ PROVIDER TRANSFER		□ OTHER:
□ OTHER:		

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE **X. _____** **PRINTED NAME:** **X. _____** **RELATIONSHIP TO PATIENT:** **X._____ DATE: _____** **THOMAS P. SENTER, M.D.** **636 BARROW STREET** **ANCHORAGE, ALASKA 99501**		** I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME BY SENDING SUCH WRITTEN NOTICE TO DR. THOMAS P. SENTER, ATTENTION: OFFICE MANAGER, 636 BARROW STREET, ANCHORAGE, AK 99501. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT MY PHYSICIAN HAS RELIED ON THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONTEST A CLAIM. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.**