AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION:

Patient Printed Name_____ Date of Request_____

Patient Address_____ Date of BIRTH_____

_____

Home Phone_____ Cell Phone _____

Patient's Email _____@_____

Authorized Representative * making request (if other than the patient): _____
(PRINT NAME LEGIBLY)

**Authority of Authorized Representative:* ☐ *Guardian* ☐ *Health Care Power of Attorney* ☐ *Health Care Surrogate* ☐ *Parent of Minor Child* ☐ *Personal Representative of Deceased Patients Estate*

REQUEST RECORDS FROM :

I hereby authorize The Alfa Doc, LLC, PO Box 2507, 154 Fairbanks Drive, Valdez, Alaska 99686 whose telephone numbers are (Phone) 907-835-ALFA (2532) & (Fax) 855-556-6395,

TO RELEASE INFORMATION TO (where you'd like us to send your records):

_____
(Name of Hospital and/or Practice(s) name OR other medical facility and it's authorized employees/agents)

whose address is: _____ Phone # _____

_____ Fax # _____

Please check one:

- ☐ Mail to company/individual at above address
- ☐ Fax to # listed above
- ☐ Hold for pick up
- ☐ The Alfa Doc, LLC may discuss my health information VERBALLY with the above listed

INFORMATION TO BE RELEASED (check all that apply):

- ☐ My complete medical record
- ☐ My medical records for the dates. _____ to _____
- ☐ Discharge Summary
- ☐ Lab Tests
- ☐ History & Physical Exam(s)
- ☐ Emergency Dept Records
- ☐ Operative Reports/Consults
- ☐ X-Ray Reports
- ☐ Physician Office Reports
- ☐ Other records (specify**)_____

***If requesting Behavioral/Mental Health records, Substance Abuse Program records, or HIV records please complete the 2nd page of this form.*

_____ _____

Signature *Date*