AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION:

Patient Printed Name____ Date of Request________________

Patient Address____ Date of BIRTH_________________

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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, 157 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*