AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT INFORMATION:

Patient Printed Name_____ Date of Request_____

Patient Address_____ Date of BIRTH_____

_____

Home Phone_____ Cell Phone _____

Patients 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 (who has your records now):

I hereby authorize _____

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

whose address is: _____ Phone # _____

_____ Fax # _____

TO RELEASE INFORMATION TO:

The Alfa Doc, LLC
PO Box 2507
157 Fairbanks Drive
Valdez, Alaska 99686

Phone #: 907-835-ALFA (2532)
Fax # : 855-556-6395

Please check one:

☐ Mail to The Alfa Doc, LLC at above address
☐ Fax to: 1-855-556-6395
☐ Hold for pick up
☐ Discuss my Health Information verbally

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*