Authorization for Release of Medical Information

Patient:____ **Date: ___________________**

Address:____ **DOB: ___________________**

____

City/State/Zip:___________________________________ **Phone: (____)____________**

I authorize *Alaska Family Dermatology, LLC* to:

___ Send copies of my record to (or discuss information with) the provider/person/facility below

OR

___ Receive copies of my record from (or discuss your information with) the provider/person/facility below.

Name of Provider/Person/Facility:____
Address:____
City/State/Zip: ____
Phone: _________________________________ **Fax: ______________________________________**

Information to be disclosed:
______Most Recent Visit Note
______Pathology Reports
______Lab Reports (last 12 months)
______Operative Notes
______ Full Medical Record

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. There may be a charge for the requested records. The records above may be faxed in the case of medical necessity. This authorization may be canceled at any time by submitting a written request to Alaska Family Dermatology, LLC.

I have read the above Authorization for Release of Medical Information and acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Representative Signature: ___________________________Date: ____________
Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): _____________________________________
Printed name of Authorized Representative: _____________________________________