ALASKA FACIAL PLASTIC SURGERY & ENT

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Authorization to Request, Disclose & Release Protected Health Information

I authorize Alaska Facial Plastic Surgery & ENT to request, use or disclose a copy of the specific health information described below regarding:

Patient's Name: ______________________ DOB: ______________

Patient/Representative Name: ______________________ Phone: ______________

Release to/from: **Alaska Facial Plastic Surgery & ENT** Phone Number:: **907-671-6017**

Address: **3719 E Meridian Loop, STE E Wasilla, AK 99654** Fax Number:: **907-313-6857**

Release to/from: ______________________ Phone Number:: ______________

Address: ______________________ Fax Number:: ______________

Please send my records via: ☐ Mail ☐ Email ☐ Paper ☐ Fax

For range of dates from: ______________ to ______________

To be disclosed:

- ☐ Complete Medical Record(s)
- ☐ Consultation
- ☐ Pathology Report:
- ☐ Operative Report(s)
- ☐ ER/Discharge Report:
- ☐ Laboratory Report(s)
- ☐ Radiology Report(s) & CD:
- ☐ Audiogram(s)
- ☐ Other (please specify): ______________________

This information will be disclosed for the purpose of:

☐ Personal ☐ Legal ☐ Continuity of medical care

Patient Signature: ______________________ Date: ______________

(Print form and sign by hand)

Representative Name: ______________________ Date: ______________

Representative Signature: ______________________ Date: ______________