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: _____ Contact: _____

Representative Name: _____ Relationship: _____

Release to/from: Alaska Facial Plastic Surgery & ENT Phone Number: (907) 600-0030

Address: _____ Fax Number: (907) 206-7153

Release to/from: _____ Phone Number: _____

Address: _____ Fax Number: _____

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

For range of dates from: _____ to _____

To be disclosed:

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

This information will be disclosed for the purpose of:

☐ Personal ☐ Legal ☐ Continuity of medical care

Patient Name: _____ Date: _____

Patient Signature: _____

Representative Name: _____

Representative Signature: _____