



MEDICAL RECORD RELEASE FORM

Telephone: 907-562-4673

Fax: 907-562-4674

Fax: 907-562-4676

Patient Name

Date of Birth

I hereby authorize:

Name

Phone/Fax Number

To release my medical information to:

Name: Alaska Women's Cancer Care

Address: 3851 Piper St #U264
Anchorage, AK 99508

Please FAX records to: 907-562-4674

I hereby authorize Alaska Women's Cancer Care to release my medical information to:

Name: _____

Phone Number: _____

Address: _____

Fax Number: _____

Medical Information Requested:

☐

All Records

☐

Specific Records from _____ to _____

☐

Immunizations & Physical Examinations

☐

Radiology Films

Signature of Patient or Legal Guardian

Date

This release authorized the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex, (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.