

Authorization For Release of Medical Information

I authorize the release of the requested radiology reports and images

from: _____ to : _____
(date) (date)

Release to: _____

Address: _____

Phone number: _____

ANCHORAGE

3650 Piper Street, Ste A • Anchorage, AK 99508 • 907.222.4624 TEL • 907.222.4651 FAX

MAT-SU

2280 South Woodworth Loop • Palmer, AK 99645 • 907.746.4646 TEL • 907.746.4640 FAX

Patient Name

Date of Birth

Previous Name

Social Security Number

Patient Signature

Date