Release of Information (ROI)

4200 Lake Otis Pkwy #102, Anchorage AK 99508

O: 907.855.4337 F: 907.865.7910

Patient Name(s)_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

_____ Date of Birth_____

Parent/Guardian Name_____ Phone number_____

Address_____

I AUTHORIZE THE RELEASE OF PROTECTED HEALTH INFORMATION FOR THE ABOVE-NAMED PATIENT(S) AS INDICATED:

FROM: _____ **TO:** _____

ADDRESS: _____ **ADDRESS**_____

_____ _____

_____ _____

PHONE: _____ **PHONE:** _____

FAX: _____ **FAX:** _____

FORMAT: ◯ **Paper** ◯ **CD** ◯ **Pick up** ◯ **Mail to address above (CD ONLY)**

Information to be released: ◯ **Entire Medical Record including Demographics page**

◯ **Chart notes Hospital notes/reports Lab/Radiology/Pathology reports**

The following MUST be specifically requested—Please initial

☐ ***HIV/AIDS/STD Related Information*** ☐ ***Substance use DX or Treatment*** ☐ ***Mental Health information***

Date Range: ◯ **All Dates of Service** ◯ **From**_____**To**_____

Purpose: ◯ Treatment ◯ Billing ◯ Moving from area ◯ Changing Providers ◯ Legal Request

Name (print)_____ Relationship to patient(s)_____

Signature_____ Date_____

***For patients 18 years or older the signature MUST be from the patient or person with power of attorney/Guardianship regarding healthcare management