ALASKA WOMEN'S
CANCER CARE

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.