ALASKA WOMEN'S CANCER CARE

Joanie Hope, MD ● Melissa Hardesty, MD ● Thomas Burke, MD FACOG ● Linda Smith, MD

Patient Name: _____ DOB: _____

Mailing Address: _____City:_____State:_____ Zip Code: _____

Physical Address: _____City:_____State:_____ Zip Code: _____

Marital Status: _____ Preferred Pronouns:_____

Employed: YES or NO Employer: _____ SSN: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Medical information (may) (may not) be left on my voicemail at: _____

INSURANCE INFORMATION Please provide a copy of the insurance cards to the receptionist

Primary Insurance Company: _____ Policy Holders Name: _____ ☐ Self ☐ Spouse ☐ Child

Policy Holders DOB: _____ Policy Holders SSN: _____ Insurance ID#: _____

Secondary Insurance Company: _____ Policy Holders Name: _____ ☐ Self ☐ Spouse ☐ Child

Policy Holders DOB: _____ Policy Holders SSN: _____ Insurance ID#:_____

Preferred Pharmacy: _____

EMERGENCY CONTACTS

Name	Relationship	Phone	Allowed to talk with about:
_____	_____	_____	☐ Medical ☐ Financial
_____	_____	_____	☐ Medical ☐ Financial

Signature:_____Date:_____Email:_____

Let Every Woman Know (LEWK) is Alaska's gynecologic cancer awareness and support organization. If you are interested in hearing more about our programs, events and opportunities for survivors and caregivers to connect, please indicate which form of communication is preferred.

☐ phone call ☐ text ☐ email ☐ for emailed quarterly newsletter

ALASKA WOMEN'S
CANCER CARE

MEDICAL RECORD RELEASE FORM

Telephone: 907-562-4673
Fax: 907-562-4674
Fax: 907-562-4676

OFFICE USE PLEASE SIGN AND DATE THE LAST LINE ONLY

_____ _____
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.