Midnight Sun Family Medicine, P.C.
Phone: (907) 455-7123 Fax: (907) 455-7125

PATIENT CONSENT FOR RELEASE OF MEDICAL RECORDS/INFORMATION

NAME_____ DOB _____/_____/_____
_____ TREATMENT DATE
FORMER NAME(S) From/To: _____

I AUTHORIZE _____ RELEASE TO: _____
_____ _____
_____ _____
_____ _____
_____ _____

INFORMATION REQUESTED:

_☐_ PROGRESS NOTES
_☐_ LAB REPORTS
_☐_ X-RAY REPORTS
_☐_ X-RAY FILMS
_☐_ SURGICAL REPORTS
_☐_ CONSULTATION
_☐_ HOSPITAL REPORTS
_____ OTHER (LIST)
_____
_____

FOR THE PURPOSE:

_☐_ FURTHER TREATMENT
_☐_ INSURANCE CLAIMS
_☐_ WORKERS COMP.
_☐_ LEGAL REQUEST
_☐_ OTHER (LIST)
_____
_____
_____

I acknowledge that the information to be released MAY INCLUDE material that is protected by Federal Law. My check mark and my signature below authorize release of the following type of information.

Drug abuse, if any _____
Alcohol abuse, if any _____
Mental health, if any _____
HIV infection, if any _____

_____
Signature & Date

This consent for release of confidential information expires in 90 days. I understand I may review my medical records upon request. I also understand I may revoke this authorization at any time. I am aware, however, there may be records that have already been released after my original authorization and prior to this revocation. This facility, its employees, and the attending physician are hereby released from legal responsibility or liability for the release of the above information.

_____ _____
Signature & Date Witness