



## New Patient Request

Valley Medical Care is a closed practice. However, we do accept new patients through attrition, striving to match specific providers availability with new patient medical needs. Preference is given to patients who are new to the community and/or do not currently have a local medical care provider. Acceptance and/or denial is based primarily on these criteria.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Previous Medical Provider: \_\_\_\_\_

Medical Provider Phone #: \_\_\_\_\_

Reason for requested appointment and/or change to Valley Medical Care (Please be specific): \_\_\_\_\_

\_\_\_\_\_

Is there a specific provider you are requesting: If yes, please name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Do you have a family member who is currently a patient at Valley Medical Care? Yes \_\_\_ No \_\_\_

If yes, please list their name and date of birth: \_\_\_\_\_

Your current Medical Conditions: \_\_\_\_\_

Please list all current medications: \_\_\_\_\_

\_\_\_\_\_

Please complete and return form with the attached signed medical release form to Valley Medical Care.

Date Received: \_\_\_\_\_ Received by: \_\_\_\_\_ Approved by: \_\_\_\_\_

VALLEY MEDICAL CARE  
1801 Salmon Creek Lane  
Juneau, AK 99801

Phone: (907) 586-2434  
Fax: (907) 586-2446

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

**INFORMATION TO BE RELEASED FROM:**  Valley Medical Care, PC  Other (Complete below)  
Name of Physician/Facility      Address      City/State/Zip      Phone Number

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**PURPOSE OF REQUEST**  Moving  Other \_\_\_\_\_

**INFORMATION TO BE RELEASED TO:**  Self  Other (Complete below)  Valley Medical Care, PC  
Name of Physician/Facility      Address      City/State/Zip      Phone Number

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**TYPE OF INFORMATION TO BE RELEASED: (Specify date range when possible)** From \_\_\_\_\_ To \_\_\_\_\_

\_\_\_\_\_ Office Notes      \_\_\_\_\_ Lab Results      \_\_\_\_\_ X-ray Reports      \_\_\_\_\_ Complete chart  
\_\_\_\_\_ Outside Records (specify) \_\_\_\_\_

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**SELECT FORMAT FOR RECORDS:** \_\_\_\_\_ PDF DOCUMENTS ON CD

\_\_\_\_\_ VIA SECURE EMAIL \_\_\_\_\_  
(Please provide email to send records to)

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**ACKNOWLEDGMENT**

- I understand information in my record *may* include sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or related diseases, or may include information about behavioral or mental health services or treatment for alcohol and/or drug abuse. **Please Do Not release this information: INITIAL** \_\_\_\_\_
- I understand that any disclosure of information carries with it the potential for disclosure by the recipient and that the information then may not be protected by federal confidentiality rules.
- I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information released prior to the revocation.
- I understand authorizing disclosure of this health information is voluntary. I understand I am not required to sign this authorization to receive treatment. I understand that if this information is required for participation in a research study, my enrollment may be denied if I do not sign the authorization.
- I understand that I may inspect or request a personal copy of the information to be disclosed.

\*\*Please allow 5-7 business days for processing. If needed for an appointment, give appointment date: \_\_\_\_\_

**PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I hereby authorize the release of the above specified medical information contained in my patient medical record.

\_\_\_\_\_  
Date      Signature of patient or responsible party      Relationship to patient

\_\_\_\_\_  
Date      Witness

**Please Note:** Authorization valid for **90 days only** and may be revoked in writing at any time prior to 90 days by notifying the Medical Record Department. **We cannot complete your request without complete information.**