Valley Medical Care
1801 Salmon Creek Lane • Juneau, Alaska

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.

Email address is required. VMC will notify you via email regarding the status of your request.

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Mailing Address: _____

Contact Phone Number: _____

*REQUIRED 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, provider 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 #/Fax#

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 #/Fax#

_____

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) _____

VALLEY MEDICAL CARE RECORDS ARE SENT BY SECURE EMAIL

EMAIL ADDRESS_____
(Please provide email to send records to)

_____

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.**