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

_____

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) _____

SELECT FORMAT FOR RECORDS: ☐ PDF DOCUMENTS ON CD

☐ VIA SECURE EMAIL _____
(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.**