PATIENT REQUEST FOR PRIVACY PROTECTION

Phone: (907) 586-2434

Fax: (907)586-2446

This form enables you to designate and/or restrict those individuals that we may communicate with regarding your care.

Patient Name:	Date of Birth: Daytime Telephone:	
SS#:		
INFORMATION MAY BE RELEASE	ED TO: Specify individual	s or facility
Name	Relationship	DOB:
INFORMATION MAY <u>NOT</u> BE REL	EASED TO: ANY PER	RSON ANY FACILITY
Name	Relationship	DOB:
Signature of patient or responsible party	Relationship if no	ot patient Date
Witness	 Date	

Please note: Authorization is valid from the date signed and may be revoked in writing at any time by notifying the Medical Record Department. This authorization applies to communication and is not a release of records.