Allergy, Asthma and Immunology
Center of Alaska, LLC.

3841 Piper St. Suite T4-054 ● Anchorage, Alaska 99508 ● 907-562-6228 ● Fax 907-562-6868

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I. Patient Information

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City/ State: _____

II. Release Information

Information to be released from: Name: _____
(Name and address of Facility/Provider) Address: _____
Phone: _____

Information to be released to: Name: _____
Address: _____
Phone: _____

Information to be released:
□ All medical records
□ Medical records for the following dates: _____
□ Medical records relating to the following treatment/ condition:
_____
□ Other (e.g. X-rays, Bills): _____

Reason for the release:
□ Personal □ Doctor □ Attorney □ Insurance □ Other _____

III. Patient Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Allergy, Asthma and Immunology Center of Alaska based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, I must write a letter to Allergy, Asthma and Immunology Center of Alaska LLC. This information may be subject to re-disclosure and may no longer be protected by federal or state privacy laws.

This Authorization expires: _____
(If left unsigned, then 180 days from the date of this Authorization)

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name Relationship
(parent, legal guardian, personal representative)