



Improve Your Hearing...Improve Your Life!

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Ketchikan, Alaska 99901

RELEASE OF HEALTHCARE INFORMATION

Name of Patient: _____ Date of Birth: _____
(First, Middle Initial, Last) (MM/DD/YYYY)

Person Requesting Information: _____

Relationship to Patient: Self Parent Guardian
 Spouse Caregiver Other: _____

Information Requested: _____

Information should be sent to the following individual(s):

1. _____
Name Address and/or Fax Number

2. _____
Name Address and/or Fax Number

3. _____
Name Address and/or Fax Number

4. _____
Name Address and/or Fax Number

Please send this information by: Fax Mail Personal Pickup

Patient or Parent/Guardian Signature

Date

Signature of Person Requesting Information
(If not the Patient or Parent/Guardian)

Date

*The release of healthcare information will expire two years from dated signature.
The patient has the right to revoke the authorization at any time by submitting a written statement.*

FOR OFFICE USE ONLY:

The requested healthcare information was released to the above named individual(s)

via Fax Mail Personal Pickup by _____ on _____
Name Date