RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____/_____/_____ SS#: _____-_____-_____

I HEREBY AUTHORIZE: _____

PH#_____ FAX# _____

TO RELEASE RECORDS TO: **ALASKA OB-GYN ASSOCIATES, LLC**
LINDA C. WRIGLEY, MD
DEBRA R. KRISTICH-MISKILL, CNM
4200 LAKE OTIS PARKWAY, STE 101
ANCHORAGE, AK 99508
PH# (907) 569-8810 FAX# (907) 569-8813

MAIL: ____ FAX: ____ WHEN NEEDED: _____

INFORMATION REQUESTED:
_____ HISTORY & PHYSICAL
_____ DISCHARGE SUMMARY
_____ LABORATORY REPORTS
_____ RADIOLOGY
_____ CLINICAL NOTES
_____ PATHOLOGY REPORTS
_____ COMPLETE CHART
_____ OTHER (PLEASE SPECIFY BELOW)

FOR THE PURPOSE OF:
_____ FURTHER TREATMENT

_____

I acknowledge that the data to be released may include material that is protected by federal law. My initials and signature below authorize release of the following type of information.

_____ DRUG/ALCOHOL ABUSE _____ MENTAL HEALTH _____ HIV TESTING

I understand that I may cancel this authority at any time in writing, except to the extent that action has been taken in reliance on it. Unless cancelled earlier by me, this authorization will expire on the date the Protected Health Information is released either to my directed representative or me by being faxed as directed or by being placed in the United States Postal System as directed.

SIGNATURE: _____ PRINTED NAME: _____
DATE: _____ RELATIONSHIP: _____

OFFICE USE ONLY
RELEASE DATE: _____
Provider _____ Director _____ Initials: _____

Alaska Ob-Gyn Associates, LLC
Release of Medical Records & Information

Patient Name: _____

Date of Birth: _____

I Authorize Dr. Linda C. Wrigley, Debra R. Kristich-Miskill to Release my Medical Records/ Information

To: _____

_____

_____

_____

Mail:_____ **Fax:**_____ **Pick-Up:**_____

INFORMATION REQUESTED FOR THE PURPOSE OF:

____ History & Physical
____ Discharge Summary
____ Laboratory Reports
____ Radiology
____ Clinic Reports
____ Consultation
____ Complete Chart
____ Further Treatment
____ Insurance Claims
____ Workers Compensation
____ Legal Requests
____ Personal Records
____ Pathology Reports
____ Other (Please Specify Below)

I acknowledge that the information to be released may include material that is protected by Federal Law. My Initials and signature below, Authorize the Release of the following type of information.

____Drug/Alcohol Abuse ____Mental Health _____HIV Testing

This Consent is subject to revocation at any time except to the extent that the Department that is to make the Disclosure has already taken action in reliance of it. If not previously revoked, this consent will Terminate Upon:_____ (DATE). This Release is good for the term period of One Year, unless otherwise directed by the patient.

SIGNATURE: _____ **Date:** _____

Printed Name: _____ **Relation to Patient:** _____