Snow Creek Medicine, LLC
711 Barrow Street
Anchorage, AK 99501

RELEASE OF RECORDS

Patient Name:_____Date of Birth:_____
Description of Information to Be Released:

_____
Physician/person/facility/entity to release information:

Name:_____

Address:_____

Fax:_____
Physician/person/facility/entity to receive information:

Name:_____

Address:_____

Fax:_____
The purpose/reason for this release of information:

_____
I hereby authorize the use or disclosure of my health care and/or other information as described above. I understand that this authorization is voluntary. I understand that my records *may* contain sensitive information. I understand that I may revoke this authorization at any time by signing the revocation section on the second page of this release, or by notifying the individual(s) or organization releasing this information in writing, but if I do, it won't have any effect on actions taken on this authorization before my revocation was received. I understand that the individual(s) or organization releasing this information *may* condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that if the person(s) or organization authorized to receive this information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulations. To the extent that this information is required to remain confidential by federal or state law, the recipient of this information must continue to keep this information confidential. I understand that I may request a copy of this signed authorization.
This authorization expires on the following date or event:_____

Signature:_____ Date:_____
Patient Representative:_____Signature:_____
Relationship to Patient:_____

NOTE: This authorization is revoked on _____ (see attached revocation statement)

REVOCATION SECTION

I do hereby request that this authorization to release the information of:_____
(Printed Name of Patient)
Described on the reverse side of this form, be rescinded, effective _____. I understand
(Date)
that any action taken soon this authorization prior to the rescinded date is legal and binding.

Signature:_____ Date:_____

Patient Representative:_____Signature:_____

Relationship to Patient:_____