FAMILY MEDICAL CENTER

HC 60 Box 4860
Delta Junction, Alaska 99737
Phone: (907)895-5100
Fax: (907)895-5133
Quality Medical Care for the Entire Family

MEDICAL RECORDS RELEASE AUTHORIZATION

PLEASE PRINT CLEARLY & FILL OUT ENTIRELY

Patient's Full Name: _____ Date of Birth: _____

Address: _____City: _____ St: _____ Zip: _____ Phone: _____

PLEASE CHECK ONE:

☐ Sending Records to ☐ Obtaining Records from

Physician/Facility Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Information to be sent or received: (Check all that apply)

☐ Entire Record ☐ X-Ray Reports
☐ Laboratory Reports ☐ Immunizations
☐ Other **(**Specify): _____

If records exceed 40 pages please mail

When requesting Personal Records please allow for up to 7 days, with Urgent Records please allow up to 24 hours. There may be a $2.00 - $15.00 shipping fee.

The patient or patient's representative must read and initial the following statements:
ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2) I understand the health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.
Initial _____

This authorization expires a year from the date of signature, or on: _____

_____ _____
Signature of Patient or Patient's representative Date

_____
Relationship to Patient

_____ _____
Witness Date