DIAGNOSTIC HEALTH ALASKA

Alaska's Home for Medical Imaging Since 1984

Authorization for Release of Information

Name: _____ **Date of Birth:** _____

☐ **I authorize the Diagnostic Health Alaska to release information to:**

_____
Name of Person, Provider, or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

☐ **I authorize the Diagnostic Health Alaska to obtain information from:**

_____
Name of Person, Provider, or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) ☐ **Healthcare** ☐ **Insurance Coverage** ☐ **Personal** ☐ **Other**

Please Check All Appropriate Boxes:

☐ Mail ☐ Pick-Up ☐ Fax to: _____

☐ Radiology Report ☐ Radiology Image ☐ Laboratory / Diagnostic Tests

☐ All Records ☐ Billing Summary ☐ Other: _____

☐ **Dates of Service** _____

Signature: _____ Date: _____

Relationship to Patient ☐ Parent ☐ Legal Guardian

☐ Other: _____

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