



*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:*

E-Mail \_\_\_\_\_  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: \_\_\_\_\_

**Diagnostic Health Alaska**

**www.dhaalaska.com**

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