DIAGNOSTIC
HEALTH
ALASKA

Alaska's Home for Medical Imaging Since 1984

4100 Lake Otis Parkway, Ste. 102, Anchorage, AK 99508

Authorization for Release of Information

Name: ______________________________ **Date of Birth:** ______________________________

☐ **I authorize the Diagnostic Health Alaska To release information to:**	☐ **I authorize the Diagnostic Health Alaska to obtain information from:**
______________________________	______________________________
Name of Person, Provider, or Facility	**Name of Person, Provider, or Facility**
______________________________	______________________________
Address	**Address**
______________________________	______________________________
City, State, Zip Code	**City, State, Zip Code**
______________________________	______________________________
Phone #/Fax # (Include area 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: ____

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