Release of Records

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505 W. Northern Lights Blvd Suite 104
Anchorage, AK 99503

Date_____

Patient: _____
Date of Birth: _____

Please release my records:
Labs_____ Imaging/X- rays _____ Entire Record_____

Dates to be included: (circle) All Last 2 years Other _____

From:

Clinic or Doctor: _____

Fax: _____

Address: _____
_____

If the **record is greater than 20 pages** please mail them.

To:

Dr. Madeleine Morrison
505 W. Northern Lights Blvd Suite 104
Anchorage, AK 99503

Patient Signature: _____

Date _____