LEGACY
HEALTH CLINIC

AUTHORIZATION TO RELEASE PATIENT HEALTH RECORDS

Information to be released from:

_____

_____

_____

Information to be released to:

LEGACY HEALTH CLINIC, LLC
JESSICA R. PILCHER, ANP-BC
HELEN R. KLEIN, FNP-BC
SARAH E. BASS, FNP-C
3524 TONGASS AVENUE
KETCHIKAN, ALASKA 99901
P: 907-225-6355
F: 907-228-7095

( ) All my records in your possession.
( ) Lab reports (specify)
( ) X-Ray reports (specify)
( ) Access to Alaska's Prescription Drug Monitoring Program

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS virus, sexually transmitted diseases, psychiatric disorders / mental health, or drug and/or alcohol use. If I have been tested diagnosed or treated for HIV/AIDS virus, sexually transmitted diseases, psychiatric disorders / mental health, or drug and/or alcohol use, you are authorized to release all health care information relating to such diagnosis, testing or treatment.

_____

DATE Signature of Patient or Legally Responsible Party

PATIENT NAME:_____

ADDRESS:_____

CITY/ STATE:_____

DATE OF BIRTH:_____

PHONE:_____