ANCHORAGE RADIATION ONCOLOGY CENTER
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Dr. Larry Daugherty Dr. William Magnuson Dr. Jason Harmon Dr. Shauna Birdsall

Authorization for Release of Protected Health Information (PHI)

Patient Name:_____ **Birth Date:**_____

Address:_____ Phone #:_____

City/State:_____ Fax #:_____

Reason for Request: ☐Second Opinion ☐Coordination of Care ☐Personal ☐Legal Use ☐Insurance

Records Requested:

☐**All PHI, including confidential**
☐Laboratory Results
☐Imaging Reports
☐Other:_____(Please Specify)
☐Chart Notes
☐Pathology Reports
☐Procedure/Operative Reports
☐Please indicate Date Range (if any): _____-_____

Delivery Method: ☐Fax ☐Mail ☐Pick-up ☐Other:_____

NOTE: If left unchecked delivery will be at the discretion of the releasing office.

PHI to be released from: _____

Address:_____ Phone #:_____

_____ Fax #:_____

PHI to be released to:_____

Address:_____ Phone #:_____

_____ Fax #:_____

This authorization is valid for:

☐One time disclosure
☐A continuing disclosure for treatment not to exceed 12 months

Patient/Legal Representative Signature:_____ Date:_____

Name (if signed by other than patient):_____ Relation:_____