



**advanced**  
SONOGRAMS OF ALASKA

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## **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to  
release healthcare information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax# \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.