FULLER DIAGNOSTICS, LLC

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: ___________________________________ **Date of Birth:** _________________

I authorize FULLER DIAGNOSTICS, LLC to release/obtain information as stated below from the patient health information record:

Release To/From: Name:_______________________________ Phone:______________ Fax: ___________

Address:______________________________________ Email:________________________

Release To/From: Name: Fuller Diagnostics, LLC. Phone: (907)561-0552 Fax: (907)561-0562

Address: 2600 Denali Street Suite 450, Anchorage, AK 99503 Email: info@fulleralaska.com

Information to be Released via: ☐ Email ☐ Fax ☐ Mail ☐ Verbal

Email/Fax Number/ Mailing Address: ____

Information to be Released: ____

Dates of service for information requested:

Beginning: _________________________________ thru _________________________________

Purpose of Release:

☐ Continuing care ☐ Copies for own use ☐ Transfer to another provider

☐ Legal ☐ Coordination with School ☐ Other: ______________________

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this Authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This Authorization will expire one year from the date signed below unless another date or event is entered here ____________.
Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

☐Mental Health Treatment ☐Sexually Transmitted Diseases ☐AIDS/HIV Treatment

☐Alcohol/Drug Abuse Treatment

Name of Responsible Party [print]: ____
Signature of Responsible Party: _________________________________ Date: _____________
Relationship to the Patient: ____

To be filled out by FULLER DIAGNOSTICS, LLC:

Date Records were released: ____
Signature of Employee: ____