Dr. Peter Lawrason, PC
1919 Lathrop Street, Suite 101 Fairbanks, AK 99701
Phone: (907)452-1622 Fax: (907)452-1664

REQUEST FOR MEDICAL RECORDS

_____Release Information To _____Obtain Information From

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone Number: (____) _____ Fax: (____) _____

Information Requested

_____ Records from the Time Period: _____ through: _____

_____ All OB/GYN records to include labs and radiology

_____ Other _____

_____

Requesting information purpose of: _____Transfer Care _____ Referral _____ Personal Records

In Accordance with Federal Regulation (42 CFR, Part 2)
I hereby consent to the release of any and all alcohol and/or drug treatment records under the same conditions outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances. All authorizations must be signed by the patient or by an authorized person in the case of a minor or physically or mentally disabled patient. I understand that this authorization is valid for sixty (60) days.

_____ I understand that information in my health record may include information relating to Sexually Transmitted Infection, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol &/or drug abuse & genetic testing; my signature authorizes release of any such information.

- *A copy of the original signed release should be treated as an original*
- *A photo ID is required to pick-up all records*
- *Please allow up to 1 week for record processing*

The Requestor May Be Provided with a copy of this authorization

Patient Name: _____ Date of Birth: _____

Primary Contact Number: _____ Alternate Contact Number: _____

Signature of Patient/Guardian: _____ Date: _____