

**PROVIDENCE KODIAK ISLAND MEDICAL CENTER
SPECIALTY CLINIC
P.O. BOX 123 KODIAK, AK 99615
PHONE (907) 486-9589
FAX: (907) 486-9586**

RECORDS RELEASE

I, _____, (patient or legal guardian) hereby request that

Dr. _____ provide records to _____

as a report of treatment, diagnosis, prognosis and recommendations for treatment, as well as any

other data pertinent to my treatment during the period from _____ to _____

regarding the following symptoms/complaints: _____

for patient: _____, date of birth: _____.

Signed: _____ Date: _____

Witnessed: _____ Date: _____

Please make records available by: _____

(allow 3-4 working days for processing.)