



1915 E. Rezanof Drive  
Kodiak, Alaska  
99615

Tel 907 486 3781

**AUTHORIZATION FOR  
DISCLOSURE OF MEDICAL RECORD INFORMATION**

Patient's Name: \_\_\_\_\_

Date of Birth or Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

The undersigned hereby authorizes and requests \_\_\_\_\_  
\_\_\_\_\_ to provide **Providence Kodiak Island  
Medical Center** with copies of my medical records for the purpose of review and  
examination.

- ( ) - Confined to records regarding admission and treatment for the following  
medical condition or injury \_\_\_\_\_  
\_\_\_\_\_ on or about \_\_\_\_\_.
- ( ) - Covering records for the period from \_\_\_\_\_ to \_\_\_\_\_.
- ( ) - Confined to the following specified information \_\_\_\_\_  
\_\_\_\_\_.
- ( ) - No limitations placed on dates, history of illness, or diagnostic and  
therapeutic information including any treatment for alcohol and drug  
abuse. (Initials of signer should appear for authentication of this  
request.)

Expiration date of this authorization, if any, \_\_\_\_\_.

\_\_\_\_\_  
Patient's Signature Date

(NOTE: If signed by other than patient; state relationship and authority to do so.)

**ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT IS  
PROHIBITED EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE.**

(c:consents\disclosu.aut)