

**813 Lower Mill Bay Rd.**

**Kodiak, AK 99615**

**P: (907) 486-4499**

**F: (907) 486-8211**

**Permission for Release of Records**

This authorization is effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_ ending \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize *Arctic Physical Therapy Services, Inc.* to disclose my health care information including:

\_\_\_\_\_ All Records

\_\_\_\_\_ Medical Records pertaining to the following injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Medical Records for the following dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the following Recipient(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledged and agreed to by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*Note that there is charge for records at a rate of .50 per page. An invoice will be included with records.\*\*\*