



2841 DEBARR ROAD | SUITE 100 | ANCHORAGE, AK 99508 | (907) 276 - 2400

PATIENT AUTHORIZATION

Patient Name _____ Date _____

I, _____ authorize the Anchorage Radiation Therapy Center Staff to send and/or discuss my past, current, and future medical records to/with the following physicians and hospitals:

PHYSICIAN/HOSPITAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I, _____ authorize the following individual(s) to discuss and/or request my medical issues/records on my behalf:

INDIVIDUAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

BILLING RECORDS

I, _____ authorize the following named individuals to discuss my billing related information with the office and billing service staff.

INDIVIDUAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I, _____ understand that I have the right to revoke authorizations assigned above at any point in time with the understanding that any records released or information communicated prior to this revocation were duly authorized.

 Patient Signature

 Date