AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I Authorize: _____ To Release to: Peak Medical Equipment LLC
_____ 1102 E Northern Lights Blvd
Anchorage, Alaska 99508

Please Release:

□ Entire Medical Record

□ Chart Notes From _____ To _____

□ Other _____

Purpose of Release:

□ Continued Medical Treatment

□ Legal / Insurance

□ Other _____

Please Send Records To:

Fax Number: (206)374-8248

I have had the opportunity to review and understand the contents of this authorization. I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment.

I understand that this authorization may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from the date of my signature. A copy of this authorization will be considered as valid as the original.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: _____ Date: _____

Or Legal Representative: _____ Relationship: _____
(Print Name)

Witness: _____ Date: _____