MILLER DERMATOLOGY
SURGICAL & LASER CENTER

636 Barrow Street, Anchorage, Alaska 99501
Phone 907-276-1315 - Fax 907-278-7129

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____
Previous Name (if applicable): _____ Social Security #: _____
Phone #(s): _____

I request and authorize **MILLER DERMATOLOGY** to

☐ RELEASE TO or ☐ RECEIVE FROM

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

the health care information on the above-mentioned patient.

This request and authorization applies to:

- ☐ Records relating to specific dates of service:
  from_____ to _____
- ☐ Complete medical record
- ☐ Pathology and/or laboratory reports
- ☐ Other: _____

Patient/Representative Signature: _____
Relation to patient: _____ **Date signed**: _____

********** THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED**********