KIDNEY & HYPERTENSION
CLINIC OF ALASKA

Jeremy Gitomer, MD
Amala Kanury, MD
Trang Ngo, MD
Benjamin Lawson, MD
Shuang Ying Bao, MD
Lisa Roberts, MD
Stephanie McQuillin, APRN
Shannon Yoder, APRN

RELEASE OF HEALTHCARE INFORMATION

Patient's Name:	Date of Birth:
Parent/Guardian Name (if minor):	

I request and authorize **Kidney & Hypertension Clinic of Alaska** to release/share healthcare information including diagnosis, records, examination results, medication dosage, claims information, and scheduling. This information may be released to:

☐ Spouse _____ Phone _____

☐ Parent/Guardian _____ Phone _____

☐ Child _____ Phone _____

☐ Child _____ Phone _____

☐ Other _____ Phone _____

☐ Information is not to be released to anyone other than me

MESSAGES

Please call ☐ my home phone number _____ ☐ my cell number _____

If you are unable to reach me: ☐ You may leave a detailed message OR ☐ Leave message for return call

☐ Do not leave messages on my phone mailbox

This release of information will remain in effect until terminated by me in writing. This release *specifically excludes* any psychiatry and psychology evaluation/records which are further restricted by HIPAA regulations.

Patient Printed Name: _____

Patient Signature: _____

Date Signed: _____

Parent/Guardian: _____

Witness: _____

4015 Lake Otis Pkwy Ste. 101, Anchorage, AK 99508
Phone: 907-375-5200 Fax: 907-375-5201