**John Boston D.O. • Jen Cox, PA-C**
**Amy Johnson, ANP**
INTERNAL MEDICINE
**950 E. Bogard Rd., Ste. 228 Wasilla, AK 99654**
**Phone (907) 376-8938 Fax (907) 376-8939**

# RELEASE OF MEDICAL INFORMATION

**Patient Name:** _____ **Date of Birth:** _____

**Treatment Dates (please be specific):** _____

**I authorize Dr. Boston's office to release the following medical information to the party listed below:**

**Release to:** _____ **Relationship:** _____

**Phone Number:** _____ **Fax Number:** _____

**You may use or disclose the following health care for my continued care:**

| | |
|---|---|
| _____**All Records** | _____**History and Physical** |
| _____**Discharge Summary** | _____**Lab Reports** |
| _____**X-Ray/Radiology Reports** | _____**Emergency Room Reports** |
| _____**Consultation Report** | _____**Pathology Reports** |
| _____**Medication List** | _____**Mental Health** |
| _____**Legal Request** | _____**Other:** _____ |

**Exclusions:**

_____

**I request the records to be (choose one)** _____ **Paper Copies or** _____ **CD**

**Signature:** _____ **Date:** _____

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**This authorization has been revoked:**

**Signature:** _____ **Date:** _____

**Reason:** _____