**Midnight Sun Oncology Partners, LLC**
**2490 S. Woodworth Loop**
**Suite 499**
**Palmer, AK 99645**
**Phone: (907) 746-7771**
**Fax: (907) 746-7798**

# RELEASE OF MEDICAL INFORMATION TO ANOTHER PARTY

Patient Name: _____ Birth Date: _____

I authorize **Midnight Sun Oncology** to release the following medical information to the party listed below.

**Release to:** _____
_____
_____
Phone: (_____)_____ Fax: (_____)_____
Relationship: _____

Information requested to be released:
___ History and Physical
___ Discharge Summary
___ Laboratory Reports (most recent)
___ Radiology Reports (all)
___ Consultation(s) (initial & most recent)
___ Pathology Reports (all)
___ Other: _____
___ Other: _____

For the purpose of:
___ Further Treatment
___ Insurance Claims
___ Legal Request
___ Other: _____

I acknowledge that the data to be released MAY INCLUDE material that is protected by Federal Law. My **initials** and my signature below authorize release of the following type of information:

____ Drug/Alcohol Abuse Information ____ Mental Health ____ HIV Information

This consent is specifically for any and all information created from services provided before or after the date of my signature to be used as needed.

Printed Name: _____ Signature: _____ Date: _____

Witness: _____ Witness Signature: _____ Date: _____