Solstice Medicine & Wellness, LLC
475 Riverstone Way, Suite 2
Fairbanks, Alaska 99709
Phone: (907) 456-6334
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of request: _____

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ___ Zip code: _____

I authorize (Clinic or Provider name) _____ to release

the following medical records to (Clinic or Provider name): _____

_____ **Complete Medical Record**	_____ All Chart notes between _____
_____ All labs and Imaging	_____ Flow Sheets(Vital signs/ Height/Weight)
_____ Medication List	_____ Mental Health Record
_____ STD/HIV Status	_____ Other: _____

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the staff member of Solstice Medicine & Wellness. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Patient Signature: _____ Date: _____