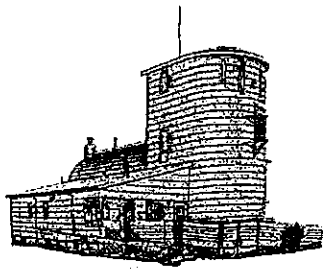

BETHEL FAMILY CLINIC
P.O. Box 1908 631 4th and Main St.
Bethel, Alaska 99559
Ph: 907-543-3773 Fax: 907-543-3545

Request for Release of Medical Records

Date: _____

Release Records **FROM**: Bethel Family Clinic
PO Box 1908
Bethel, AK 99559
Phone: 907-543-3773 fax: 907-543-3545

Release Records **to**:

_____
Provider's Name

_____
Provider's Address

_____
City, State and Zip Code

_____
Phone AND Fax Number

The below named patient is requesting and authorizing release of all specified Medical Records in your possession, concerning overall healthcare, illnesses and treatments administered for the period: From_____ to_____

OR

Request limited to the following tests and diagnosis: _____

_____

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH:_____ SSN:_____

PATIENT OR GUARDIAN'S SIGNATURE:_____

If guardianship, relation to patient:_____