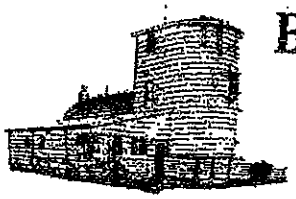

Bethel Family Clinic
Box 1908
Bethel, Alaska 99559

Release of Medical Records

Date: _____

Release Records **FROM**:

_____
Provider's Name

_____
Provider's Address

_____
City, State and Zip Code

_____
Phone AND Fax Number

Release Records to:

Bethel Family Clinic
PO Box 1908
Bethel, AK 99559
FAX: 907-543-3545

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:_____