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Dwight Ellerbe, MD
James Kallman, MD
Steve Schaffer, MD
Mark Brandt Lorenz, MD
Staci Johnson, ANP

Kaylyn Hum, AUD
Jamie Burford, AUD
Stefan Harris BC-HIS
Elise Blomfield, RN
Loduska Kirchner, RN
Audra McKellar, Esthetician

3841 Piper Street Suite T-230 | Anchorage, AK 99508
Phone: 907-279-8800 | Fax: 907-279-8810 | www.ACENTAlaska.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize ACENT to:

- o release
- o receive

To/From:

Office/Doctor Name: _____

Address: _____

Phone: _____ Fax: _____

Please choose from the following methods:

- o Mail
- o Fax
- o Pick Up

This request and authorization applies to:

- o Healthcare information relating to the following treatment, condition or dates:
  _____
- o All Healthcare Records
- o Other:
  _____

Additional Information: _____

Patient Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

_____INTERNAL USE ONLY_____

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