

Midnight Sun Oncology Partners, LLC  
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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: \_\_\_\_\_