Arctic Physical Therapy Services

813 Lower Mill Bay Rd.
Kodiak, AK 99615
P: (907) 486-4499
F: (907) 486-8211

Permission for Release of Records

This authorization is effective _____ ending _____.

I, _____ authorize *Arctic Physical Therapy Services, Inc.* to disclose my health care information including:

_____ All Records

_____ Medical Records pertaining to the following injury:

_____

_____ Medical Records for the following dates: _____

To the following Recipient(s):

_____

_____

Acknowledged and agreed to by:

_____
(Print Name)

_____ Date: _____
(Signature)

Date of Birth: _____ SSN: _____

Phone: _____

Email: _____

Note that there is charge for records at a rate of .50 per page. An invoice will be included with records.