RECORDS RELEASE AUTHORITY

TO/FROM:_____

_____

I, _____hereby request that
(patient's name or guardian)

you release to/from:

JANA K. COLE, M.D. / DANIEL W. SUVER, M.D.
2741 DEBARR ROAD, SUITE C-215
ANCHORAGE, AK 99508

Telephone: (907) 563-2002
Fax: (907) 562-7628

A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from _____to_____

_____ _____
(Date of Request) (Patient's Signature)

_____ _____
(Witness) (Address)

_____ _____
(Date) (City, State, Zip Code)