ANCHORAGE
RADIATION THERAPY
CENTER

RICHARD T. CHUNG, MD
BERIT L. MADSEN, MD
CAROL L. SWARTS, MD

2841 DEBARR ROAD | SUITE 100 | ANCHORAGE, AK 99508 | (907) 276 - 2400

PATIENT AUTHORIZATION

Patient Name _____ Date _____

I, _____ authorize the Anchorage Radiation Therapy Center Staff to send and/or discuss my past, current, and future medical records to/with the following physicians and hospitals:

PHYSICIAN/HOSPITAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I, _____ authorize the following individual(s) to discuss and/or request my medical issues/records on my behalf:

INDIVIDUAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

BILLING RECORDS

I, _____ authorize the following named individuals to discuss my billing related information with the office and billing service staff.

INDIVIDUAL	AUTHORIZATION REVOKED (DATE)
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

I, _____ understand that I have the right to revoke authorizations assigned above at any point in time with the understanding that any records released or information communicated prior to this revocation were duly authorized.

_____ _____

Patient Signature Date