2555 Phillips Field Road
Fairbanks, AK 99709
Phone: (907) 371-1766 Fax: (907) 531-7365
Email: revivemedspaak@gmail.com

Authorization for Release of Medical Information

Patient's Name: _____Date ofBirth: _____

Address: _____ City:_____ State: ____ Zip: _____

Phone # _____ Social Security #: _____

Date of Request: _____

Medical records requested (check all that apply):

- ☐ **All health records**
- ☐ **Imaging reports**
- ☐ **Lab reports**
- ☐ **Progress notes**
- ☐ **Procedure notes**
- ☐ **Other: _____**

I authorize Revive Medical Spa to receive records from:

Facility Name/ Provider Name: _____

Address: _____ City:_____ State: ____ Zip: _____

Phone # _____ Fax #: _____

PLEASE FAX RECORDS TO REVIVE MEDICAL SPA, FAX # (907) 531-7365

_____ _____
Signature of Patient or Representative **Date**

_____
Relationship to Patient