



Patient Name: _____

Patient Account # _____

**Release of Personal Health Information
Family and Friends**

I authorize Anchorage Women’s Clinic, LLC to release my personal health information, “PHI”, to the following:

1. _____ Relationship: _____

2. _____ Relationship: _____

By signing below you agree that Anchorage Women’s Clinic, LLC may release “PHI” to the above individual(s). This release will remain in effect for one year from the date signed below.

If you wish to cancel this release you must do so in writing directed to:

HIPPA Compliance Officer
Anchorage Women’s Clinic, LLC
3260 Providence Dr. Suite 425
Anchorage, AK 99508

Your request will be processed within 48 hours unless otherwise specified. Please call 907-561-7111 if you have additional questions.

Signature: _____

Date _____

Date of Birth: _____