ANCHORAGE & VALLEY
RADIATION
THERAPY
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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	PHYSICIAN SPECIALTY	AUTHORIZATION REVOKED (DATE)
1.	_____	Referring	_____
2.	_____	Primary Care	_____
3.	_____	Surgeon	_____
4.	_____	Medical Oncologist	_____
5.	_____	Other	_____

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.	_____	_____

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