Authorization for use and disclosure of Health Information

Patient name to release:_______________________ Date of birth:_________________________

Parent/guardian(s) name:______________________ Phone number:_______________________

I authorize Dr. Michael Koropp to release any pertinent x-rays and/or treatment information to the following:

☐ Dentist____

☐ Oral Surgeon____

☐ Primary Care Physician____

☐ Family Member(s)/Guardian(s)____

☐ Other____

I understand that I have the right to revoke this authorization in writing at any time except to the extent that information has already been released. I understand that I may request a copy of this authorization. I understand that a photocopy/fax of this authorization is as valid as the original. I understand that there may be a fee for copying associated with this request. **I hereby authorize the use or disclosure of the health information as described above.**

____ _____________________

Patient Signature (parent/guardian if under 18) Date

2601 Boniface Pkwy Ste. 5
Anchorage, AK 99504

2700 W Dimond Blvd St. 1
Anchorage, AK 99502

907-338-8999 Fax 907-337-5715
907-248-8999 Fax 907-245-0423