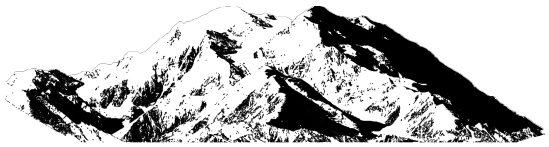

McKinley
Orthopedic & Sports Medicine

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Phone Number: _____ Social Security #: _____

I request and authorize

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number _____ Fax Number _____

To release all healthcare information to
Dr. Daniel R Johnson, D.O./Ambria "Tommie" Patacek-PA-C.

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

Timothy Carey, DO | **Daniel Johnson, DO** | **Jennifer Malcom, DO** | **Tommie Ptacek, PA-C**
3745 Geist Road, Fairbanks, Ak 99709 | Office: 907.456.3338 | Billing: 907.456.3341 | Fax: 907.456.3443