

# Release of Records

Madeleine Morrison N.D.  
615 E. 82<sup>nd</sup> Ave, Suite302  
Anchorage, AK 99518  
(907) 245-7669 Fax (907) 245-7670

Date \_\_\_\_\_

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please release my records:

Labs \_\_\_\_\_ Imaging/X- rays \_\_\_\_\_ Entire Record \_\_\_\_\_

Dates to be included: (circle) All Last 2 years Other \_\_\_\_\_

From: (circle or fill in)

Total Health Clinic Inc.  
4001 Lake Otis Parkway, Suite 200  
Anchorage, AK 99508  
Fax (907) 563-0748

Natural Health Center LLC  
3330 Eagle St  
Anchorage, AK 99503  
Fax (907) 561-1282

Other:

Clinic or Doctor: \_\_\_\_\_

Fax: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

If the record is greater than 20 pages please mail to the address below.

To:

Dr. Madeleine Morrison  
615 East 82<sup>nd</sup> Ave. Suite 302  
Anchorage, AK 99518  
Fax (907) 245-7670

Patient Signature: \_\_\_\_\_

Date \_\_\_\_\_