**Solstice Medicine & Wellness, LLC**
**Gina Escobar, M.D.**
**475 Riverstone Way, Suite 2**
**Fairbanks, AK 99709**
**Phone: 456-6334**
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# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date of request: ____________________

Patient Name: __________________________________________ Date of Birth:_______________

Address: ________________________________ City: _____________ State: ___ Zipcode: _______

I authorize (Clinic or Provider name) ________________________________________________ to release the following medical records to Solstice Medicine & Wellness:

___ Complete Medical Record

___ All Chart notes between _______________ and _______________

___ All labs and imaging ___ Flow Sheets (vitals, height, weight) ___ Medication List

___ Mental Health Record ___ STD/HIV Status

___ Other: _____________________________________________________

Restrictions: Only medical records from this healthcare facility will be copied unless otherwise requested. This authorization is valid only for releasing medical information dated before and including the date on this authorization unless other dates are specified.

I understand that I may revoke this authorization at any time. I know that if I do so, I must do so in writing and present my written revocation to a staff member of Solstice Medicine & Wellness. I understand the revocation will not apply to information already released in response to this authorization. The revocation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

Patient Signature: __________________________________________ Date:____________________