ALASKA NATURAL HEALTH SOLUTIONS, INC.
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hearby authorize Alaska Natural Health Solutions to obtain copies of all medical records regarding testing, treatment, and consultations provided to me by:

_____

I hearby authorize that a photocopy of this authorization be accepted with the authority as the original. This document will remain valid for a period of one year.

_____ _____
SIGNATURE **DATE**

_____
PRINTED NAME

_____
DATE OF BIRTH

_____
SOCIAL SECURITY NUMBER