



Bobbie Behrens, MD, OB/GYN, LLC
35670 Kenai Spur Highway, STE 101 B
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8/25/2022

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ **(DOB:)** _____

Other name(s): _____

I hereby request that _____ provide the following copies of my medical records:

___ **All**, including diagnosis, treatment prognosis and recommendations, labs, imaging, office notes and hospital records.

___ **Specifically**, _____

Date(s) of service: _____

For the purpose of: ___ Further Treatment ___ Insurance Claims ___ Legal Request

___ Personal ___ Other (please list) _____

Please send to:

Bobbie Behrens, M.D. & Kathryn Flores, MSN, FNP
35670 Kenai Spur Hwy, STE 101B
Soldotna, AK 99669
(907) 262-2615 phone (907) 262-8842 fax

I acknowledge that data to be released may include information protected by Federal Law (alcohol/drug, mental health, HIV/STD's) and I consent to its release.

Signature

Date

Witness

Date

Request completed by _____ Date _____