THE STATE of ALASKA

GOVERNOR BILL WALKER

Department of Health and Social Services

DIVISION OF PUBLIC HEALTH
Section of Epidemiology

3601 C Street, Suite 540
Anchorage, Alaska 99503
Main: 907.269.8000
Fax: 907.562.7802

CONSENT FOR RELEASE OF MEDICAL INFORMATION

TO: _____

Name of Provider, Clinic, or Hospital

_____

Complete Mailing Address City/State Zip

I hereby give my consent to have any pertinent records and information related to the medical care of tuberculosis for:

_____ _____

Name Date of Birth

To be sent to:

Alaska Tuberculosis Program
Section of Epidemiology
3601 C Street, Suite 540
Anchorage, AK 99503
Fax: (907) 563-7868

_____

Signature of Patient/Legal Guardian/Parent

_____

Relationship to Patient

_____

Mailing Address

_____

City State Zip

Witness _____

Address _____

Date _____