



**RECORDS RELEASE AUTHORITY**

To/From: \_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_ hereby request that  
**(Printed name and DOB)**

you release to/from:

JANA K. COLE, MD / DANIEL W. SUVER, MD  
JAMES J. LEE, MD / AARON E. BERHANU, MD

2741 Debarr Road, Suite C-215  
Anchorage, AK 99508

A report of my diagnosis, treatment, prognosis and recommendations, as well as other  
data pertinent to your treatment of me from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
**(Date of Request)**

\_\_\_\_\_  
**(Patient's Signature and DOB)**

How would you like to receive your records

Pick up at Plastic Surgeons of Alaska

Mail or Email

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

Fax

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