

Alaska Physicians & Surgeons, Inc.
Authorization for Release of Information

This signed authorization, or a photostatic copy thereof, constitutes the authority for the release of personal and information concerning the undersigned to the agents representatives, and/or employee(s) of Alaska Physician & Surgeons, Inc.

I specifically authorize any and all physicians, educational institutions, medical societies, medical board specialty groups, any state medical board, insurers, and health care institutions and their respective staffs, agents, and employees to provide copies of documents and to consult with the representatives, agents, and/or employees of Alaska Physicians & Surgeons, Inc. concerning information of professional licensure, education, clinical training, Board Certification, affiliation with the responding health care entity, professional liability insurance and malpractice history, disciplinary actions including suspensions, voluntary or involuntary, denial of privileges, and revocation of licensure or privileges.

Social Security Number

Signature

Date