Dwayne Trujillo, MD, Elizabeth deSchweinitz, MD

Candace Carson-McCollum, FNP

9500 Independence Drive, Suite 700 Anchorage, AK 99507

Phone: 907-569-3600 Fax: 907-569-3200 Email: frontdesk@akdocs.com

January 10, 2022

To our esteemed patients,

With heavy hearts we are sending this letter to let you know that we have decided to retire from our Family Medicine practice. We have treasured getting to know each of you, and are honored that you have trusted us to provide you with medical care during our time in practice – 35 years for Dr. deSchweinitz, 30 years for Dr. Trujillo, and 25 years for FNP Carson-McCollum.

Our last day of scheduled appointments in the clinic will be April 29, 2022. We will be available for a short period of time after that date to assist our patients with active medical issues needing follow-up and with medication refills. We have attached a medical release of information form that you can fill out and transmit back to us in order to authorize transfer of your medical records to a new clinic. We are also maintaining a resource list of local clinics that state they are accepting new patients which is available to you upon request via email.

We encourage you to reach out to us and let us know what your needs are as we go through this process of transfer of medical care together. We can be reached by any of the contacts listed above.

Again, we feel blessed to have provided you with medical care and wish you and your family the best of health and wellbeing.

Respectfully,

Dwayne Trujillo, MD

Elizabeth deSchweinitz, MD

Candace Carson-McCollum, FNP

Authorization to Release Confidential Health Information

Elizabeth deSchweinitz M.D, Dwayne E Trujillo M.D, Candace Carson-McCollum, ANP
Please note that each provider is a separate entity
9500 Independence Dr., Suite 700, Anchorage Alaska 99507
Phone: 907-569-3600 Fax: 907-569-3200

Name:_____ DOB:_____ SSN#: XX-XXX-_____

I consent to the **mutual exchange** by hand delivery, fax, mail or telephone of confidential information as necessary for medical treatment, payment and health care operation during the next 12 months. I authorize this office to:

[ ] Release info to: **[ ] Obtain info from:**

Name of Organization:_____

Address: _____

Phone_____ Fax:_____

Purpose of Information:

[ ] Treatment Planning
[ ] Personal Use
[ ] Continued Treatment
[ ] Legal Use
[ ] Coordinate Treatment
[ ] Employment Assistance
[ ] Other _____

Information Requested:

Treatment Dates From: _____ to _____
[ ] Admissions/Discharge Summaries
[ ] Medical Office Chart Notes, Consult Notes
[ ] Medication Records
[ ]] Lab Results
[ ] X-Ray Results
[ ] Immunization Records
[ ] School Records (specify)_____
[ ] Other_____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse the right to sign this authorization. I understand that I may revoke this authorization at any time. In order to revoke this authorization I must do this in writing and present this to my health care provider or designee. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact my health care provider or designee at 907-569-3600.

SPECIFIC AUTHORIZATION FOR RELEASE

I authorize the release of the information listed at the right which requires specific consent under federal law:

Type of Information	Authorizing Initials
Mental Health eval/treatment	
AIDS/HIV-related	
Substance abuse	

_____ _____
Client Signature (optional for minors/adults with guardians) Date

_____ _____
Relative/Guardian/ Authorizes Person Relationship

Office Use Only:
[ ] Send for Records [ ] Release Records Date Records sent:_____ By Whom:_____