



Release of Information

3340 Providence Dr., Ste. 452
Anchorage, AK 99508
Phone: 907-562-2120 Fax: 907-562-6527

Chart # of Patient: _____ Primary Provider: _____
Patient Name: _____ Date of Birth: _____
Parent/Guardian Name: _____ Phone Number: _____
Address: _____

I authorize LaTouche Pediatrics, LLC 3340 Providence Dr., Suite 452, Anchorage AK 99508 to release the following medical information to the party listed below.

Release To: _____

For patient's added protection, it is the policy of LaTouche Pediatrics, LLC. NOT to fax records. Records may be picked up at any of our office location. **As of 12/01/2009 all medical records will be formatted on CD unless stated otherwise.**

Check box if requesting printed copy of medial records.

Records to be picked up at: Please mail records to:
 3340 Providence Dr., Suite 452 Address: _____
 1301 Huffman Rd., Suite 110 _____
 17101 Snowmobile Lane, Suite 203 _____

Information requested to be released: For the purpose of:
 LaTouche Pediatrics, LLC Chart Notes Treatment
 Discharge Summaries Payment/Billing
 Laboratory Reports Worker's Compensation
 Radiology Reports Legal Request
 Emergency Reports Personal Records
 Pathology Reports Moving out of Area/State
 Consultation Reports Changing Practices
 Other: _____

I acknowledge that the information to be released **MAY INCLUDE** material that is protected by Federal Law. My initials below and my signature below authorize the release of the following information.

_____ Drug/Alcohol Abuse Information _____ Mental Health _____ HIV Information

This consent is specifically for information created from services provided before the date of my signature. Information related to services provided after the date of my signature will require an updated authorization. In addition, this consent is subject to revocation in writing at any time except to the extent that the department that is to make the disclosure has already taken action in relation to this release. If not previously revoked, this consent will terminate on: _____ (date not to exceed 90 days). Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by the HIPAA Privacy Regulations.

Name (please print): _____ Signature: _____
Relationship to Patient: _____ Date: _____
Staff Witness: _____ Date: _____

This section to be completed by LaTouche Pediatrics Administrative Staff

_____ Number of pages Copied Charges: _____ Payment collected by: _____
Records Prepared By: _____ Payment Type: _____
Prepared on: _____ Records picked up/Mailed Date: _____
I.D. Verified by: _____