



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
1301 Huffman Rd., Suite 110
17101 Snowmobile Lane, Suite 203
Address:

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

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: