



Release of Information

3340 Providence Drive, Suite 452
Anchorage, Alaska 99508
Phone: 562-2120 Fax: 562-6527

Chart # of Patient: _____

Primary Provider: _____

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Phone Number: _____

RELEASE TO: LaTouche Pediatrics, LLC

Release From: _____

Address: _____

Contact Number: _____

Information requested to be released:

- Chart Notes
- Discharge Summaries
- Laboratory Reports
- Radiology Reports
- Emergency Reports
- Pathology Reports
- Consultation Reports
- Other: _____

For the purpose of:

- 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 Received

Records Received By: _____

Received on: _____