



Release of Information

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

Patient Name: _____

Date of Birth: _____

Parent/Guardian Name (if patient is under 18): _____

Phone Number: _____

Address: _____

Primary Caregiver: _____

I authorize LaTouche Pediatrics, LLC to release the following information to the party listed below:

Release To: _____ Phone Number: _____

For your 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 locations. **As of 12/01/2009 all medical records will be formatted on CD unless stated otherwise.**

Check box if requesting printed copy of medical records.

Records to be picked up at:

OR

Records to be mailed to:

- 3340 Providence Dr., Suite 452
- 1301 Huffman Rd., Suite 110
- 17101 Snowmobile Lane, Suite 203
- Verbal Information Only

Address: _____

Information requested to be released:

- Entire Chart
- Date Range: _____ to _____
- All Dates of Service

Or Specific Information:

- Chart Notes
- Discharge Summaries
- Lab Reports
- Radiology Reports
- Pathology Reports
- Emergency 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

(any information protected by Federal Law must be specifically requested by initialing below)

_____ *Drug/Alcohol Abuse* _____ *Mental Health (not including psychotherapy notes)* _____ *HIV/STD 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: _____ (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): _____

Relationship to Patient: _____

Signature: _____

Date: _____

(If patient is over 18 years old, signature must be that of the patient, not their parent/guardian)