



Consent and Authorization for Parents of Non-Minor Patients

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

Today's Date _____

Patient's Name _____ Date of Birth _____

This is my authorization and consent for the below named person or persons to act on my behalf in regards to receiving information from or making requests to LaTouche Pediatrics, LLC. I acknowledge that granting authorization to the individuals listed below, to request services on my behalf, does not release me from financial responsibility.

Please initial all that apply (signature at bottom of page is also required)

- _____ Request/Receive Medical Records
- _____ Full access to Patient Portal Account
- _____ Request prescriptions
- _____ Pick up prescriptions (*excluding controlled substances*)
- _____ Pick up controlled substance prescriptions

Person(s) authorized for the activities initialed above:

Name

Relationship to Patient:

_____	_____
_____	_____
_____	_____

This authorization will remain in effect for one year unless so designated in writing that such consent is cancelled.

Expiration Date (*less than one year*): _____

Print your Name

Signature

Date