Release of Information

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

All information must be completed fully and accurately before protected health information is released.

Patient Name: _____ **Date of Birth:** _____

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

Address: _____ Primary Caregiver: _____

I authorize the release of protected health information for the above named patient as indicated below:

Release From: _____ **Release To:** _____

Address: _____ Address: _____

_____ _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Secure Email: _____ Secure Email: _____

For our patient's added protection, it is the policy of LaTouche Pediatrics, LLC NOT to send records to unsecure fax numbers or email addresses. Records may be picked up at any of our office locations if being released to a patient or parent/legal guardian.

Format: AND

☐ Paper
☐ CD
☐ *Verbal Information Only*

Sent by: OR

☐ Mail
☐ Secure Fax (30 pages or less)
☐ Secure Email

Records to be picked up at:

☐ 3340 Providence Dr., Suite 452; Anchorage, AK 99508
☐ 1301 Huffman Rd., Suite 110; Anchorage, AK 99515
☐ 17101 Snowmobile Lane, Suite 203; Eagle River, AK 99577

Information requested to be released:

☐ Entire Chart
Or Specific Information
☐ Chart Notes
☐ Discharge Summaries
☐ Lab Reports
☐ Radiology Reports
☐ Pathology Reports
☐ Emergency Reports
☐ Consultation Reports
☐ Other: _____

Date Range:

☐ From: _____ To: _____ OR ☐ All Dates of Service

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***

I understand this consent is specifically for information created from services provided before the date of my signature and any information related to services provided after the date of my signature will require an updated authorization. I understand 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). I understand this authorization is voluntary and LaTouche Pediatrics, LLC will not condition the patient's treatment on whether this authorization is provided. I understand 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)