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

_____ Request prescriptions

_____ Pick up prescriptions *(excluding controlled substances)*

______ Pick up controlled substance prescriptions

______ Speak to a Triage Nurse and receive medical advice on my behalf

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