ANCHORAGE PEDIATRIC GROUP

Release of Information

3340 Providence Drive, Suite 500-Building A, Anchorage, AK 99508
T. 907-562-2423 / F. 907-563-1170

Patient Name: _____ Date of Birth: _____

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

Address: _____

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

Release Records **FROM**: _____
Address: _____
_____
Phone: _____
Fax: _____

Release Records **TO**: _____
Address: _____
_____
Phone: _____
Fax: _____

Please tell us how you would like to receive the records:

Format: *AND*
☐ Paper (only available for pick up and less than 30 pages)
☐ CD

Sent by: *OR*
☐ Mail
☐ Secure Fax
_____

Records picked up at:
☐ 3340 Providence Dr. #A500
Call at this phone number when ready:
_____

Information requested to be released
(please check all that apply):
☐ Entire Medical Record
☐ Lab Reports
☐ Chart Notes
☐ Radiology Reports
☐ Pathology Reports
☐ Emergency Reports
☐ Other: _____

Date Range:
☐ Past 3 years
☐ From _____ to _____
☐ All Dates of Service

For the Purpose of:
☐ Treatment
☐ Legal Request
☐ Personal Records
☐ Billing
☐ Moving out of the area
☐ Changing practices/providers

Any information protected by Federal Law must be specifically requested by initialing below:
_____ HIV/AIDS/STD related test results
_____ Drug/alcohol diagnosis and treatment
_____ Mental health information

I understand that I may cancel this authorization at any time by giving written notice to *Anchorage Pediatric Group, LLC*. Unless canceled at an earlier date, this authorization will expire one year from the date of signing below, or on _____.

Name (please print): _____ Relationship to Patient: _____

Signature: _____ Date: _____
(If patient is over 18 years old, signature must be that of the patient and NOT the parent/guardian.)

OFFICE USE ONLY
(circle one) Faxed/Picked Up/Mailed

Date: _____ Initials: _____