Anchorage Pediatric Group, LLC
3340 Providence Drive, Suite 500, Building A
Anchorage, Alaska 99508
Phone: 907-562-2423 · Fax: 907-563-1170

We apologize ahead of time- We CANNOT fax whole records that are more than 30 pages.
Please tell us how you would like to receive the records.
Circle: MAIL FAX PICKUP EMAIL

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, _____
(Parent/Guardian Name)

Hereby authorize the disclosure of the following protected health information:

Records of: _____ Date of Birth: _____
(Child/Patient's Name)

For the purpose of: ___ Continuity of Care ___Other:_____

TO:
Name: _____
Address: _____
_____
_____
Phone: _____**Fax:** _____
Email: _____

FR:
Name: _____
Address: _____
_____
_____
Phone: _____**Fax:** _____
Email: _____

Please Check All that Apply:
__Entire Medical Record
__Lab or Pathology Reports
__Medical Records for Continuity of Care
__Clinician Office Chart Notes
__Diagnostic Imaging Reports
__Billing Statements
__Other (specify) _____

*The following items must be **initialed** to be included in the use or disclosure of other health information:
__*HIV/AIDS-related information
__*Genetic Testing Information
__*Mental Health Information
__*Sexually Transmitted Diseases
__*Drug/Alcohol Treatment/Referral (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the re-disclosure of such information.)

I understand that I may revoke this authorization at any time by giving written notice to Anchorage Pediatric Group, LLC. Unless revoked earlier, this authorization will expire 1 year from the date of signing or upon _____ [insert desired expiration date].

I understand that Anchorage Pediatric Group, LLC will not condition treatment of eligibility for care on my providing this authorization. I may inspect a copy of any information to be used or disclosed under this authorization.

I also understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as denied in 42 CFR Part 2, may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations.

_____
Signature of Patient/Legal Representative

_____
Printed Name of Patient/Legal Representative

_____
Date of Signature

_____
Contact Phone #

FOR OFFICE USE ONLY

Form of ID Checked:
__Driver's License#:_____
__Military ID
__Other: _____

_____ _____
Witness Signature **Date**