



Alaska Center for Pediatrics

BIRTH THROUGH ADOLESCENT CARE
1200 Airport Heights Drive Suite 140
Anchorage, Alaska 99508
(ph) 907.777.1800
(fax) 907.278.2066
www.akpeds.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Release: [] From [] To Release: [] From [] To (please list)

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Information Requested:

- [] Current Physical [] Medication Lists [] Labs/test results
[] X-ray/Diagnostic reports [] ER/Hospital records [] Consults
[] Psychiatric reports [] Complete records [] Other: _____

Purpose of the Request:

- [] Patient request [] Continuation of care [] Termination of care
[] Insurance request [] Other: _____

[] Yes [] No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq. includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhoea.

[] Yes [] No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

[] Yes [] No I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I consider a copy of this authorization to be as valid as the original. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations. I understand that I may see and obtain a copy of the information described on this form if I ask for it and that I may get a copy of this form after I sign it. I understand that a fee for copies may be imposed by the person(s)/organization(s) listed above or by its designated business associate. I understand that the first complete records request will be provided free of charge. All subsequent requests over the next 5 (five) years, will incur a \$30 fee.

Signature: _____ Date Signed: _____

Printed Name: _____ [] Parent [] Legal Guardian [] Patient