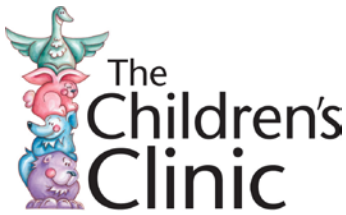

Daniel Tulip, MD
Janet Shen, MD
Jeanette Legenza, MD
James Foster, MD
Yekaterina Batilova, MD

PATIENT NAME ______________________________ **PATIENT DOB** ________________

REQUESTING A PERSONAL COPY OF YOUR CHILD'S MEDICAL RECORD (exclude billing record)
There is no fee for the first copy in a calendar year; the fees below will apply to additional copies requested in the year and are collected before the request is completed. Please allow up to ten business days to complete this request.

Requested Format

Format	Fee	
Electronic (CD)	$7.00	☐
Email	$5.00	☐
Printed	$14.00	☐

I acknowledge that there may be security risks once PHI leaves your systems and I am aware that the email will not be encrypted. I understand that a third party may be able to read or otherwise access my records while in transit.

Requested Method of Delivery

I will pick up my copy ☐
I will send an email initiating the request ☐
Mail it to me (address below) ☐

Street______________________________

City____________, State_____, Zip_________

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Keep the authorization on file for future requests ☐ **Complete the request now** ☐

This authorization permits The Children's Clinic, Inc. to use and/or disclose the following individually identifiable health information to:

Person / Place to Receive Information:

Name:______________________________________

Phone:________________ Fax:_________________

Street:______________________________________

City____________, State__________, Zip_________

Reason for Request:

Moving ☐ Change of Providers ☐
Treatment ☐ School / Camp ☐
Legal, Job, or College ☐ Payment and Billing ☐
I am 18 and authorize my parent / guardian ☐
Other_____________________________

Information to be released:

Entire Medical Record (exclude billing record) ☐
Office notes regarding medical issue of _____________
____

Physical and Immunization Record ☐
Office notes for date(s) of service_________________
____

I acknowledge that material released MAY INCLUDE material that is protected by federal law. My initials here and signature below authorize release of the following types of information: ___Substance abuse ___Mental Health ___HIV

This authorization expires on __________________________(Expiration Date or Defined Event) or 90 days from date of signature. I do not have to sign this authorization in order to receive treatment from The Children's Clinic. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by federal and state law. I have the right to revoke this authorization in writing except to the extent that the clinic has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy and Security Officer, at 4001 Dale Street Suite 213, Anchorage AK 99508-5496.

Signed by: ________________________________ ________________________________
Signature of Patient or Legal Guardian *Relationship to Patient*

________________________________ ________________________________
Print Name of Patient or Legal Guardian *Date*

PATIENT/GUARDIAN MUST BE PROVIDED WITH A COPY OF AUTHORIZATION

4001 Dale Street, Suite 213, Anchorage, AK 99508
P: (907) 562-2944 F: (907) 562-6321
INFO@TCCPEDS.COM