Ptarmigan Connections

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Authorization to Release and Use Patient Health Information

By signing this authorization, I authorize Ptarmigan Connections to receive records from or disclose records to (as indicated below) certain protected health information **for the purpose of providing continued medical care for my child, at my request**. I understand that this information will be kept in my child's file. I understand my signature on this form is completely voluntary and is not a requirement for treatment in this clinic. I have had an opportunity to ask questions and my questions have been answered.

Child's Name: ____ **Date of Birth:** _____________________

The purpose of obtaining information is to get a complete medical and developmental history. This information is essential to providing a comprehensive evaluation, as well as to avoid unnecessary testing and duplication. This authorization permits Ptarmigan Connections to

[ ] Request records be **sent from**… [ ] **Send** records **to**… [ ] **Verbal** exchange of all information

For records being sent from Ptarmigan Connections, please check **one** box for delivery and **one** for type:
Delivery: [ ] Mail (provide address below) [ ] Pick-up [ ] Fax: _______________________ **Type** of copy: [ ] Paper [ ] CD

Please check all that apply	Please print name & phone number of provider	Office use only Reg/Rec
☐ Primary Physician	____	________
☐ Eye exams	____	________
☐ Hearing test	____	________
☐ Hospital records	____	________
☐ Lab, MRI, CT scan, EEG	____	________
☐ Infant Learning Program	____	________
☐ Occupational Therapy	____	________
☐ Speech Therapy	____	________
☐ Physical Therapy	____	________
☐ Psychiatry	____	________
☐ Psychology/Counseling	____	________
☐ Other (please list)	____	________
☐ Other (please list)	____	________
☐ Other (please list)	____	________

Records may contain sensitive information regarding drug, alcohol, or mental health treatment, as well as AIDS/HIV status, sexually transmitted diseases, genetic testing, etc. If required, the signature of the minor below also indicates consent.

Minor Patient Signature: ____ Date Signed: ______________________

I understand that this authorization expires **one year** from the date the form is signed, unless I submit a written request to the clinic prior to that date. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name of Parent or Legal Guardian (circle one): ____

Signature of Parent or Legal Guardian (circle one): ____ **Date:** ________________

Parent/guardian will be provided a signed copy of this form upon request.