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 Birth Name: _____ Date of Birth: _____
Also known as: _____

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.

For records being sent from Ptarmigan Connections, please check **one** box for delivery and **one** for type:
Delivery: ☐ Email ☐ Pick-up ☐ Fax: _____ **Type** of copy: ☐ Paper ☐ CD

Please check all that apply	Please print name, phone/fax number or email	Send from	Send to	Verbal exchange
☐ Primary Physician	_____	☐	☐	☐
☐ Eye exams	_____	☐	☐	☐
☐ Hearing test	_____	☐	☐	☐
☐ Hospital records	_____	☐	☐	☐
☐ ☐ birth records	_____	☐	☐	☐
☐ Lab, MRI, CT scan, EEG	_____	☐	☐	☐
☐ Infant Learning Program	_____	☐	☐	☐
☐ OT/ST/PT	_____	☐	☐	☐
☐ Psychiatry	_____	☐	☐	☐
☐ Psychology/Counseling	_____	☐	☐	☐
☐ Specialist	_____	☐	☐	☐
☐ School District - ESER/IEP	_____	☐	☐	☐
☐ School – MAP/PEAKS/Aims WEB	_____	☐	☐	☐
☐ Other (please list)	_____	☐	☐	☐

LEGAL NOTIFICATIONS Minors Only: A minor patient's signature is required to release the following specific information. Conditions relating to productive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (pertains to minors age 14 and older). • Substance Abuse diagnosis or treatment and mental health conditions (age 13 and older).

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.