Ptarmigan Connections, LLC

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Authorization to Release and Use Patient Health Information

By signing this authorization, I authorize Ptarmigan Connections, LLC 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, LLC to ☐ Request records be **sent from**… or ☐ **Send** records **to**…

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)	_____	_____

For records being sent from Ptarmigan Connections, check one box: ☐ Mail (see above) ☐ Pickup ☐ Paper ☐ CD ☐ Fax:_____

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 (check one): _____

Signature of same: _____ Date: _____

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