Ptarmigan Pediatrics | 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.

Patient Name: _____ Date of Birth: _____

Release from Name/Facility:	Release to Name/Facility:
Complete Address:	Complete Address:
Phone: Fax:	Phone: Fax: Email:

PURPOSE FOR REQUESTING INFORMATION (please mark each option that applies)

	Personal Use		Continuation of Care		Transfer of Care
	Legal Use		Insurance Use		Other(please specify):

I AUTHORIZE THE FOLLOWING TO BE RELEASED FROM MY MEDICAL RECORDS:

	Last 6 months of records		Last year of records		All medical records
	Other (please specify):				

******Some records may contain sensitive/confidential information and require a separate permissions acknowledgement. Please INITIAL below for authorization to release these specific records.**

	Alcohol/Substance Abuse Records		Genetics Records		Mental Health Records
	Sexually transmitted disease or testing records		Neuropsychological or FASD evaluation reports		

Delivery Options: ● _____ Secure E-mail ● _____ Secure Fax ● _____ Pick-up ● _____ Mail ● _____ Verbal

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).
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.

Patient signature (even if a minor IF REQUIRED):	Parent/Guardian Signature:
Patient Printed Name:	Parent/Guardian Printed name: Relationship to patient:
Today's Date:	Today's Date:

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