Ptarmigan Pediatrics, LLC
950 E Bogard Rd Ste 233
Wasilla, AK 99654
907-357-4543 (ph); 907-357-4533 (fax)

Authorization to Release and Use Patient Health Information

By signing this authorization, I authorize Ptarmigan Pediatrics, LLC to receive or disclose (as indicated below) certain protected health information **for the purpose of providing continued medical care for my child, at my request**. I understand my signature on this form is completely voluntary and is not a requirement for treatment in this clinic.

Child's Name: ____ Date of Birth: ________________________

This authorization permits Ptarmigan Pediatrics, LLC to [ ] Request from… and/or [ ] Disclose to…

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… the following individually identifiable health information (choose those that apply):

[ ] Current physical and immunization records
[ ] Complete medical records.
[ ] Particular dates of service: From _____ / _____ / _____ to _____ / _____ / _____
[ ] Other: ____

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: ____

Signature of Parent or Legal Guardian: ____

Date: ____

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