

## PERMISSION TO TREAT AND DISCLOSURE (PTTD) FOR MINORS

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Patient phone

\_\_\_\_\_  
Primary Care Provider

**Authorized Individual:**

\_\_\_\_\_  
Full Name (please print)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
DOB (please print)

\_\_\_\_\_  
Phone



**Minor (Age 14 - 17) consenting to disclosure (PRINT NAME)**



**Parent/Legal representative consenting to disclosure (PRINT NAME)**

I have agreed to authorize certain individuals to participate in discussions and decisions related to my or my child's medical care.

I hereby give my permission for The Children's Clinic to disclose my or my child's personal protected health information (PHI) to the individual listed above.

**Please initial disclosure for all categories below:** \_\_\_\_\_

The Children's Clinic may disclose medical information to the individual listed when I am not physically present, including disclosures by telephone, fax, e-mail or regular mail.

Refill/pick-up medication prescriptions

Call for medical advice

Schedule/cancel appointments

Pick-up completed forms

**Please initial below to authorize the release of the following confidential information:**

\_\_\_\_\_ Contraceptive management

\_\_\_\_\_ HIV/AIDS/STD evaluation/treatment

\_\_\_\_\_ Alcohol/drug abuse evaluation/treatment

\_\_\_\_\_ Behavioral/mental health evaluation/treatment

The Children's Clinic will not disclose confidential information unless medically necessary.

I understand that this consent may be revoked by me at anytime by written notice to The Children's Clinic.

\_\_\_\_\_  
Patient or Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Access Revoked Signature

\_\_\_\_\_  
Date