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 _____