PROVIDENCE MEDICAL GROUP ALASKA
PEDIATRIC NEUROSCIENCES CLINIC
AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

The purpose of obtaining/releasing information is to have complete record of medical and developmental history. This information is essential for providing a comprehensive evaluation, recommending appropriate services, and avoiding unnecessary testing and duplication.

PATIENT NAME:_____ **DATE OF BIRTH:** _____

The following people have been or will be involved with my child's care. I authorize mutual exchange of information between the PEDIATRIC NEUROSCIENCES CLINIC and:

Check all that apply:	**Agency/Program:**	**Provider name:**	**Phone number:**
☐ Primary Physician			
☐ Eye exams			
☐ Hearing Test			
☐ Infant Learning Program			
☐ School Records			
☐ Psychology/ Counseling			
☐ Speech Therapy			
☐ Occupational Therapy			
☐ Physical Therapy			
☐ Other:			
☐ Other:			

I understand that this information will be kept in my child's file and will not be released without my permission. All practices of confidentiality will be followed in the use of the information gathered. This release is valid for twelve months after date signed. I have had an opportunity to ask questions and have my questions answered.

Signature:_____ **Date**: _____

Print Name: _____ **Relationship to Child:** _____

Address:_____

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