Children's Medicine, P.C.
Teen Contact Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of that a communication of PHI be made by alternative means.

To be completed by patient.
Please write clearly so we do not have trouble contacting you.

I, _____ wish to be contacted in the following manner regarding my office visit
(Print Patient Name)

on **_____.**
(Date of Service)

Please initial **ALL** that apply:

Patient Cell Phone _____

_____ Leave message with call back number only.

_____ Leave message with results/details.

Home Phone_____

_____ Leave message with call back number only.

_____ Leave message with results/details.

If we may discuss lab results and office visit details with someone other than yourself, please initial and list below:

_____ _____ _____
Name Phone Number

_____ _____ _____
Name Phone Number

Patient Email _____

_____ Send message with call back number only.

Patient Signature _____ **Date** _____

*Must be signed.

1/25/2019