Center for Pediatric Medicine

Our Family Caring For Yours

CONFIDENTIAL COMMUNICATION AUTHORIZATION

Name of patient(s): ____ DOB: _______________

I, ____________________________________, hereby request the use of the following methods of communicating confidential health information related to my child's personal health, treatment, or payment for treatment.

My home phone number: ____

My cell phone number: ____

My work phone number: ____

My email address: ____

My preferred methods of contact are:

Medical issues: ☐ Home phone ☐ Cell phone ☐ Work phone

Appointment reminders: ☐ Home phone ☐ Cell phone/SMS ☐ Work phone ☐Email

Recall: ☐ Home phone ☐ Cell phone ☐ Work phone

General notices: ☐ Home phone ☐ Cell phone/SMS ☐ Work phone

___ I authorize Center for Pediatric Medicine, PC to leave detailed messages about my child's health (including test results, medications, etc.) on the voicemail of my preferred phone number.

___ Do not leave detailed messages on any voicemail or answering machine (person-to-person contact with parent/guardian only).

___ Restrictions: ____

____ ______________________

Parent/Guardian signature Today's date