

Lakeview Pediatrics

Consent for Contact

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 or that a communication of the PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

1. I wish to be contacted in the following manner: (If you are 18 or older, first contact should be your name)

First Contact Name Relationship:

First Contact Number __ cell __ home __ work *It is NOT ok to leave a message with details*

Second Contact Name _____ Relationship: _____

Second Contact Number _____ __ cell __ home __ work *It is NOT ok to leave a message with details*

Third Contact Name _____ Relationship: _____

Third Contact Number _____ __ cell __ home __ work *It is NOT ok to leave a message with details*

2. Appointment reminder preference (choose ONE):

text to number: _____
 call to number: _____
 email to email address: _____

3. Alternate contact authorization - if desired for grandparents, nanny/babysitters or patient's parents if patient is > 18 yo:

I give authorization for Lakeview Pediatrics to discuss/leave a message regarding the information below with the person listed here:

Name: _____ Relationship to patient: _____

Number: _____ *I give permission to leave a message at this number*

Scheduling appointments

Appointment reminders

Account information such as billing/amount due

Treatment/test results

Note: the following information will only be disclosed if specifically checked below:

Behavioral/Mental Health Information can be discussed

Drug/alcohol diagnosis, treatment and referral information can be discussed

Information about sexually transmitted diseases can be discussed

Birth control can be discussed

Pregnancy can be discussed

HIV/AIDS related health information can be discussed

4. Please list all children that are patients at Lakeview Pediatrics:

Patient/Child Name (print): Date of Birth:

Patient/Child Name (print): _____ Date of Birth: _____

Patient/Child Name (print): _____ Date of Birth: _____

Patient/Child Name (print): _____ Date of Birth: _____

Parent Name (print):

Signature of parent or patient (if over 18): Date:

5. My email address: