# *Lakeview Pediatrics, LLC*

## 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:**

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. Authorization:**

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:** _____