TOWN PEDIATRICS, PC

CONSENT to LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

Patient Name(s):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

I understand that my healthcare information at Town Pediatrics, PC is protected and I have received a copy of a Notice of Privacy Practices.

I further understand that, in order for Town Pediatrics, PC to leave **detailed messages containing specific medical information** on my voice mail or answering machine, I need to give permission to Town Pediatrics, PC to do so.

Consent for Leaving Messages

I consent to information regarding my or my child's (under the age of 18) lab test results or detailed appointment reminders/instructions be left on my voice mail or answering machine. I understand that "sensitive" information as noted below will be excluded. ☐ **Yes** ☐ **No**

Consent for Shared Information with Family & Friends

The name(s) listed below are family members or friends to whom I grant permission for my healthcare providers and their representatives at Town Pediatrics, PC to verbally discuss my or my child's care using their best judgment, and grant them permission to disclose health information that is relevant to my or my child's care or relevant for payment. ☐ **Yes** ☐ **No**

Under the HIPPA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your or your child's best interests even without this signature.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Records form.

I understand that some information, as listed below, is considered "sensitive." I understand that I must check boxes in order for my provider or his/her designee to discuss any "sensitive" information with the listed family member or friend.

☐ Mental Health/Psychiatric Disorders (including depression)
☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
☐ Pregnancy information
☐ HIV/AIDS Virus
☐ Sexually Transmitted Disease

NAME	RELATIONSHIP & Phone Number
1_____	_____
2_____	_____
3_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent I must provide written notice to the staff at Town Pediatrics, PC.

_____ _____

Patient/Parent/Guardian Signature Date