CHILDREN'S MEDICAL GROUP, P.C.
AUTHORIZATION TO LEAVE MEDICAL INFORMATION and/or MESSAGE

In accordance with HIPAA Privacy Rule, individuals have the right to request a restriction on uses and disclosures of their protected health information (PHI). As the parent/guardian of your child(ren), we at Children's Medical Group PC, must have your authorization as to where to leave messages. We need to know in writing what phone number(s) we may call to speak with you or with whom we may leave a message. It is our office policy to NOT release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, and/or cell phone. Whenever returning telephone calls and the answering machine picks up, we will NOT leave a message *if* the name or telephone number is not on the recorded message to identify the residence. We may simply request that you return the call. Information will also NOT be given to any unauthorized person who may answer the telephone.

I authorize Children's Medical Group physicians and/or staff to leave medical information pertaining to the care of my child(ren) with household members/answering machines/voicemail, by the following methods and will assume responsibility to notify them whenever this information changes. In addition, staff may provide information concerning appointment confirmation, rescheduling, lab results, vaccine information or nurse follow-up calls. Below are commonly used phone types with spaces for you to provide the number. ***Please provide numbers that we have permission to use and check appropriately for permission you are authorizing.***

Home Telephone ____________________
O Leave message with appointment, time & date
O Leave message regarding lab results, vaccines
O Leave medical info and/or nurse return calls
O Leave message to call office
O Do not leave message

Work Telephone ____________________
O Leave message with appointment, time & date
O Leave message regarding lab results, vaccines
O Leave medical info and/or nurse return calls
O Leave message to call office
O Do not leave message

Cell Telephone ____________________
O Leave message with appointment, time & date
O Leave message regarding lab results, vaccines
O Leave medical info and/or nurse return calls
O Leave message to call office
O Do not leave message

Fax Communication to home **Yes** _____ **No** _____
Number provided at time of need
Fax Communication to work **Yes** _____ **No** _____
Number provided at time of need
Fax Communication school/daycare
Number provided at time of need **Yes** _____ **No** _____
Mail to home address on file **Yes** _____ **No** _____

The following individuals have my/our permission to receive medical information about my/our child(ren):

NAME	RELATIONSHIP	TELEPHONE NUMBER

Child(ren) Names: 1) ______________ **DOB** ________ **2)** ______________ **DOB** ________

3) ______________ **DOB** ________ **4)** ______________ **DOB** ________

Parent/Guardian: ______________________ ______________________
(Printed) **(Signature)**

Patient Address: ______________________________

Date: ______________________