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. This information includes but is not limited to medical issues, appointment reminders, general notices, and billing issues.

My primary phone number: _____

My alternate phone number: _____

My work phone number: _____

☐ 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 primary phone number.

☐**Do not leave detailed messages on any voicemail or answering machine.**

Privacy constraints:

☐ **No constraints**

☐ **Restrictions – person-to-person with parent/guardian only.**

☐ **Restrictions – other: _____**

Email address for Patient Portal: _____

_____ _____

Parent/Guardian signature Today's date