Healthy Starts Pediatrics, PC
HIPAA PRIVACY CONTACT INFORMATION
Signature required upon check-out.

All children listed below **must reside with, and have the same guardianship and HIPAA Preferences,** or they must be on a separate sheet.

Main Contact Phone number: ( ) _____ **Mobile? or Home?**

To whom does this number belong? _____ **Mother / Father / Other** _____

Address of children listed below: _____
Street City State Zip

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Please circle your selections below: (you must have legal guardianship of all children listed to complete this form)

Which of the following methods of contact do you authorize?	**For Appointment Messages**	**With Medical Information / Results**
On Home Phone (including automatic calls)	Yes No	Yes No
On Cell Phone (including automatic calls)	Yes No	Yes No
Texts on Mobile Device (currently not active)	Yes No	Yes No
On your **work voicemail**?	Yes No	Yes No
With another person (listed below)	Yes No	Yes No
Via **US Postal Mail**?	Yes No	Yes No
Email via patient portal (currently not active)	Yes No	Yes No
Fax Immunizations or School Health Assessments to child's school upon School's request	Yes No	

Please list names and relationship of everyone for whom you authorize for the services below (if there is no one listed below, your child may not be brought to an appointment by anyone other than a parent)**:**
***Note that you must be a legal guardian or parent in order to complete this form.**

Name	**Relationship to child**	**Phone number**	**Accompany Child to appointments/Authorize vaccines & medical care**	**May Contact our office regarding appointments & medical care**
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No

_____This Authorization and above preferences are effective _____ and will remain in effect until revoked by me in writing
Date

Name of person completing this form: (must be a parent / guardian)_____ Relationship: _____

***I have read the Privacy Practices Notice for Healthy Starts Pediatrics. (A copy is available upon request**

X_____/_____
Signature of Parent / guardian **Date Completed**