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

Patient (Child's Name): _____ Date of Birth: _____

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

To whom does this number belong? _____   **Mother / Father**
                                    (must be biological parent or legal guardian)

Name of Employer for above parent: _____

EMAIL ADDRESS: (for confirmations and forms): **_____**

Address of child listed above: _____
                                    Street   **City**   **State**   **Zip**

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
- You must be a legal guardian or biological parent to complete this form
- Both biological parents are entitled to complete a form
- Step-parents have no rights by law 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

Printed Name of person completing this form: (must be a biological parent / legal guardian)_____
                                                                                    PLEASE PRINT!

Relationship: Mother   Father   Caseworker   Adoptive Parent

*I have read the Privacy Practices Notice for Healthy Starts Pediatrics. (A copy is available upon request). This Authorization is in effect until revoked by me in writing.

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