



CARING HANDS PEDIATRICS

www.caringhandspediatrics.com

Medical Information Disclosure

Caring Hands Pediatrics would like to ensure your child's health information is disclosed correctly. ***If you have restrictions regarding voice mail messages, texts or emails please provide the information below.*** If you choose no restrictions, that entitles our staff, physicians, and or representatives to leave information regarding your child's medical and financial information via email, text or phone.

Child(ren) Name(s): _____

I, _____, the undersigned, hereby authorize Caring Hands Pediatrics P.C., its representatives, physicians and staff, to share any and all medical and financial information based on my option below (Please choose only one):

***** Both biological parents will automatically have authorization unless court documents are presented specifically stating one is not authorized by the courts.***

- NO RESTRICTIONS:** Okay to leave messages on designated phone numbers and/or text or email.
- RESTRICTED:** Person to person with Parent/Guardian Only
- RESTRICTED:** See note below:

Parent Name: _____

Date: _____

Signature: _____