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

Patient Name: _____ DOB: _____

Please circle your selections below:

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 one emergency contact below in the event there is a health issue with guardian accompanying child to visit.**
Name: _____ Relationship: _____ Contact #: _____

Please list names and relationship of anyone other than biological or legally adoptive parents, whom you authorize for the services below: (Biological or legally adoptive parents will automatically be given rights to all unless otherwise specified by court order)

Name	**Relationship**	**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 will remain in effect from _____ to _____.

OR

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

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

***I have read the Privacy Practices Notice for Healthy Starts Pediatrics. (A copy is available upon request). Signature of Parent: _____ Date: _____**