PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Account Number: _____

Please list all persons who may schedule/reschedule appointments, call for medical advice or bring your child in for treatment (such as a babysitter or grandparent), pick up prescriptions and/or forms, and sign for immunizations. These individuals will be asked to present photo identification at the time of the visit. If someone other than those you list below contacts us regarding your child, we will contact you for permission to advise or treat. In the event of an emergency, we will treat and make every possible attempt to reach you.

Requests, whether written or verbal, for information related to or copies of the patient's immunization records, medical records, and/or visit history must be made by the parent or legal guardian. Please see NOTE below regarding requests from other entities.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____
Signature of Parent, Guardian, or Patient

_____
Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: _____ (Patient's Date of Birth)

NOTE: In certain circumstances, F. Read Hopkins Pediatric Assoc., Inc. is permitted or required to use or disclose protected health information without the parent's written consent or authorization. Examples include providing information to specialists for appointments and/or treatment, public health requests for immunization/medical information, and court orders. If you have any questions regarding health information disclosure, please contact our office.