

Kaplan Pediatrics and Associates

PATIENT PROTECTED HEALTH AUTHORIZATION

Please list the family members or other person, if any, whom we may inform about your child's general medical condition and your diagnosis.

Please list the family members , if any, whom we may inform about your child's medical condition ONLY IN AN EMERGENCY.

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL".

Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information (if other than your home phone number) () _____, Cell() _____, Fax() _____, Other() _____.

Can confidential messages (i.e. appointment reminders, lab results) be left on your home answering machine or voicemail? Yes _____ No _____

If you do not have voicemail, can a confidential message be left at your place of employment? Yes _____ No _____

PATIENT NAME _____

PARENT OR GUARDIAN'S NAME _____

PARENT OR GUARDIAN'S SIGNATURE _____

TODAY'S DATE _____