Authorization to Release and Discuss Medical Information

Patient Name _____ DOB_____

Please provide information on any family members or friends you want us to be able to speak with concerning your child. You may opt out by checking Do Not Release Information to Anyone. The patient's representative will choose a password or phrase which must be relayed to the office staff before Kids First Pediatrics will disclose any information concerning your child over the phone. **Chosen password _____**

Method	Contact Number	OK to leave Voicemail	OK to leave a message with another person
___Call home		___Yes ___No	___Yes ___No
___Call cell		___Yes ___No	___Yes ___No
___Call work		___Yes ___No	___Yes ___No
___Send email	Email address_____		
	___Email appointment reminders ___Email medical information or additional scheduling information ___Email office announcements		
___Regular Mail			
___Text message	If OK, please list cell carrier (e.g., Verizon, AT&T): _____ ___Text appointment reminders ___Text medical information or additional scheduling information ___Text office announcements		
___ **DO NOT RELEASE INFORMATION TO ANYONE IN ANY MANNER**			

I give the following individuals authorization to take messages or speak with Kids First Pediatrics of Georgia on my child's behalf: (please check all items authorized)

Name of authorized person_____Relationship_____
Phone Number_____
____Appointments ___Financial ___ Medical Treatment ____Insurance ___Other
Name of authorized person_____Relationship_____
Phone Number_____
____Appointments ___Financial ___ Medical Treatment ____Insurance ___Other
Name of authorized person_____Relationship_____
Phone Number_____
____Appointments ___Financial ___ Medical Treatment ____Insurance ___Other
Please mark the ways that you consent to us communicating with you:

I understand that with my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify Kids First Pediatrics of GA should I wish to change one or more contacts listed above.

Signature of Patient's Representative (or patient if over 18 yrs of age)_____
Relationship to Patient _____
Printed name of Patient's Representative_____Date signed_____