LEGACY Pediatrics

PERMISSION REGARDING COMMUNICATIONS / HIPAA FORM

I give permission to the Legacy Pediatrics staff to communicate information regarding medical care and appointments relating to:

Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____
Patient Name: _____ Date of Birth: _____

The communication can be delivered by the following (Please circle if permissible):

Appointment Message	**Medical Information**	
Home Phone	Home Phone	
Mobile Phone	Mobile Phone	Home #_____
Mobile Text	Mobile Text	Mobile #_____
Work Phone	Work Text	Work #_____
With Another Person	With Another Person	
Send via Mail	Send via Mail	
Send via Portal	Send Via portal	

I give permission to Legacy Pediatrics staff to discuss with the following listed individual(s), information reasonably deemed to be directly related to such individual's involvement in the above-referenced patients' health care: (examples: Grandparents / Relatives / Babysitters / Step-Parents, etc.)

Name: _____ Relationship to patient: _____

Phone #: _____

Name: _____ Relationship to patient: _____

Phone #: _____

I understand that I may change the above information at any time by sending my written request to my physician. Any change requested does not affect any communication previously made in reasonable reliance on this form. I have had the opportunity to receive and read the Legacy Pediatrics Notice of Privacy Practices.

_____ _____ _____

Parent / Legal Guardian (Print Name) **Parent / Legal Guardian (Signature)** **Date**