

## Patient Contact Consent Form

With all of the requirements on your time, there may arise situations when it will be necessary for someone other than a custodial parent to bring your child in for care or to call for advice. There may also be times when we need to get in touch with you about lab reports, immunizations, appointments, or other matters. In order to protect your privacy, we ask that you fill in this form **completely**. Our office will only release information to individuals listed on this form. Additionally, we will see your child only if accompanied by those listed on this form. In the event of an emergency your child will, of course, receive care as necessary to prevent death or serious injury.

**By signing this for your child, you affirm that you have legal right to give this consent.**

Our staff will only release information to the individuals listed below. It will let us know whom: 1) we can call with questions or test results; 2) is allowed to make appointments or bring your child in to be seen and 3) can give consent for routine immunizations and treatments. Please remember to list your child if you approve his/her coming in for an appointment alone or if they may make their own appointment/receive test results.

Name	Relationship	Phone # (home and work)	Cell number	*
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N
				Y/N

**\* Circle yes or no for permission to make appointments/bring child in/give consent/use as emergency contact.**

We notify our patients/families of all test results including normal findings. **Please check the box below that corresponds to how you wish us to notify you of NORMAL test results:**

- You may leave normal test results on my home/cell/work voice mail
- Do not leave normal test results on my home/cell/work voice mail.

We would also like to send out reminder cards about upcoming appointments or new information about illnesses, immunizations, or medications. **Please indicate below how you would like us to send you this information:**

- Yes, please send information to my home address
- Yes, send information, but use this address:

\_\_\_\_\_

- No, I do not wish to receive this information.

**Unless otherwise noted, consent will apply until a change is made and signed.**

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Name (printed): \_\_\_\_\_

Relationship: \_\_\_\_\_

Patient name: \_\_\_\_\_

DOB: \_\_\_\_\_

Chart # \_\_\_\_\_