Lehigh Valley Pediatric Associates, Inc.

COMMUNICATION CONSENT

It is the office policy of Lehigh Valley Pediatric Associates, Inc. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning telephone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Lehigh Valley Pediatric Associates, Inc. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home Telephone ________________________ ❑ yes ❑ no

Answering Machine ________________________ ❑ yes ❑ no

Work Telephone ________________________ ❑ yes ❑ no

Voice Mail ________________________ ❑ yes ❑ no

Cell Phone and/or Voice Mail ________________________ ❑ yes ❑ no

Pager ________________________ ❑ yes ❑ no

Fax medical records for referrals
to another entity ________________________ ❑ yes ❑ no

If you would like to have information released to someone other than yourself please complete the following:
Please list names of authorized people:

Spouse: ________________________ ❑ yes ❑ no

Parent: ________________________ ❑ yes ❑ no

Other names (please list relationship such as boyfriend, fiancé, girlfriend, sister, etc.) ❑ yes ❑ no

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Printed Name ________________________

Patient/Guardian Signature: ________________________

Date: ____________