Lehigh Valley Pediatric Associates, Inc.

Patient Communication Permission

Patient Name:________________________________ SSN: ________________ DOB: __________

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As a parent of a patient in our practice, from time to time we may need to communicate with you when you are not in the practice. To preserve your child's privacy, we would like you to indicate your preferred method for us to communicate information to you.

Without specific permission we will not release any of your child's medical or billing information to another person. In some cases you may wish for another person to have access to your child's medical information.

In the event that no one is available to answer your phone, we need permission to leave certain types of information on your answering machine or with another person. Please indicate **your preference** by checking one or more of the boxes below.

- ❑ Do not leave medical information on an answering machine or with another person.
- ❑ I give permission for Lehigh Valley Pediatric Assoc., Inc. personnel to leave any and all medical information pertaining to my child, including appointment reminders, on my home answering machine at the number listed below:

  Phone Number: ____________________________________

- ❑ I give permission to Lehigh Valley Pediatric Assoc., Inc. personnel to give any and all medical information pertaining to my child, including appointment reminders, to the individual listed below:

  Name: ____________________________________

- ❑ I give permission for Lehigh Valley Pediatric Assoc., Inc. personnel to discuss my child's account balance, insurance coverage/benefits, payment plans, payments, and history of my child's account to the individual listed below:

  Name: ____________________________________

I assume responsibility to inform the practice of changes in my phone number(s), person to discuss my child's medical and billing information, or my preference.

____
Parent/Guardian Name

____________________________________ ____________________
Signature **Date**

____
Witness