

# HIPPA Authorization Statement

Please complete the following so that we may contact you properly and securely.

- Please list family members or other persons, if any, whom we may inform about your child's general medical condition and diagnoses (including treatment, payment and health care operations).

Name .....

Phone.....

Name .....

Phone.....

- Please list the family members or significant others, if any, whom we may inform about your child's medical condition **ONLY IN EMERGENCY**.

Name .....

Phone.....

Name .....

Phone.....

- Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

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- Please print the telephone number where you want to receive phone calls about your appointments, lab and x-ray results, or other health care information if other than your home telephone number.

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- Please indicate if you want all correspondence from our office sent in a sealed envelope marked CONFIDENTIAL

Yes

No

- Can confidential messages (ie, appointment reminders) be left on your telephone answering machine or voicemail?

Yes

No

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**Patient Name** *print* (parent / guardian, if under 18 years old)

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**Patient Signature** (parent / guardian, if under 18 years old)

.....  
Date

## Notes

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