

Kids Care Pediatrics

Acknowledgement of Receipt of Privacy Notice

Communication Authorization

Kids Care Pediatrics may contact me at home/work/cell numbers, or at my home address regarding my diagnosis, results, treatment and care, or payment. I may request any other means of communication (email, different mailing address) or I may deny a particular means of communication in writing(below).

[] I may be contacted on my cell phone at _____ . I understand cell phones are NOT considered a private/secure method of communication.

[] I may not be contacted by the following means: _____

I understand that I may authorize Kids Care Pediatrics to share medical/billing information about my care or my child's care to relatives, caretakers, close friends, etc.

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Communication authorization shall be expired under any circumstances as listed below:

- 1) Upon written request for records release for reason of transfer of care.
- 2) Upon written request by patient or legally responsible person.
- 3) In case of a minor having reached the age of maturity.

Patient: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____