Island Coast Pediatrics
Request for Limitations and /or Restrictions of Protected Health Information Regarding Communication and/or Care of the Patient

Patient Name: _____Date of Birth: _____

Address: _____Suite/Box: _____City_____

State _____ Zip Code _____ Phone: _____ Alt# _____

1. I am requesting that communication NOT be sent, given or received by any of the following methods:

[ ] Phone Calls or Answering Machines
[ ] Faxes
[ ] E-Mails
[ ] Post Cards

2. I am giving permission to: _____, (please check relationship)

_____Grandparent, _____Babysitter, _____ Non-Custodial Parent, _____Other Relative

Other-specify: _____

to bring my child to Island Coast Pediatrics for treatment in my absence. I am also giving permission for confidential health information to be disclosed to them as necessary, if I am unable to be contacted. Their

Telephone number is: _____.
Note: Use one form for each person being given permission to bring child in and for each patient.

Description of the information to be used or disclosed *(check all that apply)*:
This is *not* a release of information form. Information will be used or disclosed per above instructions.

[ ] The entire medical record.

[ ] Other/Specific Information:_____

_____ _____
Patient or Guardian's Signature Date

FOR OFFICE USE ONLY
[ ] Initial **Contact** for questions re form:_____ on_____
[ ] Form and **ALERT added to patient record** by:_____ on_____

Revised: 3/11/05,
11/29/06, 07/17/08,
05/11/10, 8/1/11