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
[ ] Obtained from website
[ ] Form and **ALERT added to patient record** by:_____ on_____

Revised: 6/14/05