Emerald Pediatrics

Request for Confidential Telephone Communications

Patient Name____ DOB______________________________

I hereby request to receive confidential telephone communications from the practice in the following manner.

Phone number(s) where I wish to be contacted: __________________________ __________________________

You may leave limited protected health information on my voicemail or answering machine (lab or test results, information about scheduling or prep for a test or procedure or information regarding follow up with a specialist. Yes__________ No__________

You may communicate my protected health information with a family member (other than me or my spouse):
Yes__________ No__________

If yes, please list family member(s):

______________________ ________________________ ________________________ ______________________

Signature of the Patient / Parent____ Date________________

***Note: Emerald Pediatrics reserves the right to communicate sensitive health information only to the patient/parent.**

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