

PEDIATRICS AT WHITLOCK, P.C.
 707 Whitlock Ave. Suite D-30
 Marietta, GA 30064
 770-499-8909 (Office); 770-499-8911 (Fax)

MEDICAL INFORMATION COMMUNICATION PREFERENCES

I, _____ (print name) hereby request the use of the following channels for the communication of information related to my child's personal health, treatment, or payments for treatments. This request supersedes any prior request for confidential channel communication I have made previously. This communication applies to the following patients:

Patient	Date of Birth
Patient	Date of Birth
Patient	Date of Birth

PLEASE INDICATE YOUR PREFERENCES:

____ I give permission to leave medical information pertaining to my child or dependent at the numbers listed below:

Method	Yes (<i>okay to leave message</i>)	No (<i>do not leave message</i>)	Phone Number
Home			
Work			
Cell			
Other			

____ I give permission to release medical information pertaining to my child or dependent to the individuals listed below. These individuals also have permission to accompany my child to their pediatrician visits in the event that I am unable to.

Name	Relationship to patient	Phone number

____ Do not release medical information to anyone other than myself. Please do not leave messages on any phone number.

I assume responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature of Insured or Authorized Representative

Print Name of Insured or Authorized Representative

Relationship to Patient

Date