PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)
&
AUTHORIZATION TO CONSENT TO HEALTH CARE

Patient Name: ______________________________

Date of Birth: ______________________________

Chart #:______________________________

Parent's/Guardian's Name: ______________________________

I hereby give my permission to the person(s) listed below to: 1) bring the above named patient to the office for medical treatment or lab services and/or 2) receive information about the care of the above named patient.

NAME (First & Last)	Relationship	TREAT Only	DISCUSS PHI & TREAT
1)			
2)			
3)			
4)			
5)			

In order to obtain information by telephone, the party calling the practice must share the patient password with the staff.

______________________________ ______________________________
Signature of Parent or Guardian Signature of SFP Employee

______________________________ ______________________________
Date Date

PATIENT PASSWORD: ______________________________

*****Password is only required when the persons listed above call for test results or PHI – not parents/guardians – please make sure you remember the password because it can not be given out over the phone.**

****Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have received a copy of Shore Fun Pediatrics Notice of Privacy Practices.

______________________________ ______________________________
Signature of Parent or Guardian **Date**