ELM Pediatrics

This form authorizes ELM Pediatrics to communicate information about your care (e.g., appointments, labs, medication, treatment plans, billing information) to you and a trusted family member, friend, or caregiver. This form is optional and does not expire.

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Primary Contact Number: _____
mm/dd/yyyy ☐ Home ☐ Cell* ☐ Work

Mailing Address: _____
(Street)

_____
(City) (State) (Zip)

Methods of Communication

Phone	**Detailed Messages Permitted**		
☐ Primary Contact Number Above	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None
☐ Other: _____ ☐ Home ☐ Cell* ☐ Work	☐ via text (SMS)*	☐ voicemail/answering machine	☐ None

Email

☐ _____

☐ All information from this practice* ☐ Data breach notifications

☐ Billing and appointment information only (no treatment information)

*By checking this box, you confirm that you understand that email and standard SMS messaging are not confidential and are unsecured methods of communication. You also understand that sending your health information via email and SMS presents a risk that a third party could intercept and read your information. ELM Pediatrics does not recommend communicating healthcare information via email or SMS.

Communicating with others (not parent or guardian)

☐ ELM Pediatrics may orally communicate to the family members, friends, or caregivers listed below. Check the box next to each type of information that ELM Pediatrics may share.

☐ All Information ☐ Prescriptions ☐ Appointments (request/confirm/cancel) ☐ Billing/Insurance

☐ Name: _____ Phone: _____
First and Last

☐ Name: _____ Phone: _____
First and Last

☐ Name: _____ Phone: _____
First and Last

☐ ELM Pediatrics my **NOT** communicate with my family members, friends, or caregivers.

MULTIMEDIA AND/OR PHOTOS OF YOU OR YOUR CHILD

Photos & Multimedia (including your minor child)

☐ Photo received from you or other approved person listed on page 1
☐ Photo taken by staff (e.g., pre/post procedure)
☐ Other clinical images (e.g., X-ray)
☐ Other: _____

Photos/Images may be posted:

☐ In office
☐ On office's website
☐ Other: _____

ACKNOWLEDGEMENT AND SIGNATURE

- You acknowledge that information related to communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse might be included in a communication you authorize on this form. Information that has been shared as permitted by this form may be redisclosed and no longer protected by state or federal privacy laws.
- You can revoke or stop the communications on this form at any time in writing. It will not apply to any communications that were made before ELM Pediatrics received your written notice to stop the communications.
- An Authorization to Release Protected Health Information must be completed for ELM Pediatrics to provide copies of or transmit your health information/records to anyone other than you.
- All changes or updates to this form must be made in writing and signed by you (patient, parent or guardian).

_____

Signature | Relationship to Patient | Date (mm/dd/yyyy)

FOR OFFICE USE & REFERENCE ONLY

☐ This authorization has been revoked: _____
mm/dd/yyyy

The revocation/cancellation must be in writing and filed with the original authorization.

Date original signed authorization received: _____
mm/dd/yyyy

☐ Copy provided to parent/guardian

Notes: _____

_____

_____