Countryside Pediatric Care

Patient Name:_____ DOB: _____

I authorize Countryside Pediatric Care to register my email address so that I may voluntarily have electronic access to view and manage my child's information, medical records, request prescriptions, view past appts, etc ☐ Y ☐ N

May we leave a message for you at work? ☐ Y ☐ N

May we leave a message for you at home? ☐ Y ☐ N

May we email and/or text you appointment reminders? ☐ Y ☐ N Email Address:

May we fax your child(ren)'s shot record to his/her school if you verbally request us to do so? ☐ Y ☐ N

Name of School(s): _____

In addition to you and your insurance company, with whom may we discuss your child(ren)'s health information?

☐ Y ☐ N	Your Spouse	Name/Telephone: _____
☐ Y ☐ N	Child's Step Parent	Name/Telephone : _____
☐ Y ☐ N	Caregiver	Name/Telephone : _____
☐ Y ☐ N	Child's Grandparent	Name/Telephone : _____
☐ Y ☐ N	Child's Babysitter	Name/Telephone : _____
☐ Y ☐ N	Other Representative	Name/Telephone : _____

Pharmacy Name: _____

Pharmacy Telephone Number: _____

Pharmacy Address: _____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information and the opportunity to specify alternative means of communication of my protected health information.
I acknowledge that I have read and received a copy of the Privacy Notice.

_____ _____
Parent/Guardian/Representative Signature Date

_____ _____
Printed Name Relationship to Patient