Express Pediatric Care

HIPAA DOCUMENT FOR TEXT MESSAGES AND PHONE CALLS / VOICEMAIL

Patient Name: _____ Date of Birth: _____

Release Authorization for Parent / Guardian

Our office will implement a new system that will allow us to communicate with patients about appointment information, appointment reminders, and lab and imaging results. We may send you information about office closings, vaccination warnings, or office activities.
At the bottom put the initials next to each one who agrees to participate.
Please give us the most recent home phone number, cell phone, and email.

___ I give permission to leave voicemail messages, including information about follow-up appointments, health visits, and test results.
___ I give permission to receive text messages on my phone, including information on follow-up requirements, appointment reminders, and office closure information.
___ I give permission to receive emails, including information on follow-up requirements, appointment reminders, and office closure information.

_____ _____ _____

Home phone number Mobile number Email

_____ _____ _____

Parent / Guardian Name Parent / Guardian Signature Today's Date