

DEPENDENT PATIENT CONTACT CONSENT FOR PROTECTED HEALTH INFORMATION

*** YOU HAVE THE RIGHT TO REVOKE INFORMATION BY COMPLETING A NEW FORM ***

Please Print Below:

Name of Dependent Patient: _____ Age: _____

Name of Parent or Legal Guardian: _____

What is your relationship to this patient? _____

May we discuss the personal health information of this dependent patient with anyone else, such as another parent, step-parent, grandparent, adult child, etc.?

- YES NO

If YES, name of other person(s): _____

Relationship to patient: _____

When necessary, what phone number(s) do you prefer to be notified of Pathology, Laboratory, other test results, or answers to your questions?

Primary #: _____ Alt. #2: _____ Alt. #3 _____

- Speak only to above named individuals personally? **YES** **NO**

- May we leave a message? **YES** **NO**

If leaving a message regarding your results, your voice mail or answering machine greeting must be identifiable by name or number.

Print Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Reviewed, no changes made. Parent or Legal Guardian Initials: _____ Date: _____

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