La Pine Community HEALTH CENTER

Pediatric Disclosure of Protected Health Information (PHI)
(HIPAA Form)

Patient Name (please print): _____ DOB: _____ Date: _____

La Pine Community Health Center may: (*check all that apply*)			
*Leave **medical** information on voicemail:*	□ Cell Phone	□ Home Phone	□ None
*Leave **billing** information on voicemail:*	□ Cell Phone	□ Home Phone	□ None
Use for automated appointment reminders or general messages:	□ Cell Phone	□ Home Phone	□ None

If there is anyone that you would like to give us permission to speak with regarding your healthcare, please indicate below:

I authorize La Pine Community Health Center to speak to the following people, in person or by telephone:

1. Name: _____Relationship: _____ Phone: _____
   Regarding: □ Schedule or cancel appointments □ **All** information
   □ Other: (please specify) _____

2. Name: _____Relationship: _____ Phone: _____
   Regarding: □ Schedule or cancel appointments □ **All** information
   □ Other: (please specify) _____

List legal representative, guardian, power of attorney, etc., if any: (*must provide proof)*

1. Name: _____Relationship: _____ Phone: _____
2. Name: _____Relationship: _____ Phone: _____

If the patient is a minor, please give us the names of both parents:

Mother's Legal Name: _____ Father's Legal Name: _____

List anyone other than parents or legal guardian who may seek medical care for the minor patient: (*stepparents, grandparents, etc.)*

1. Name: _____Relationship: _____ Phone: _____
2. Name: _____Relationship: _____ Phone: _____
3. Name: _____Relationship: _____ Phone: _____

Are there any additional accommodations needed?

Please specify: _____
_____

This authorization may be changed or revoked in writing at any time. It will remain in effect until that time or until the minor patient turns 18 years of age.

Patient or Parent/Guardian Signature: _____ Relationship: _____
(If under 15 years of age, parent or legal guardian must sign)

Printed Name of Signer: _____ Date: _____
(If parent or legal guardian)