De La Vega Pediatrics

Request for Limitations and /or Restrictions of Protected Health Information Regarding Communication and/or Care of the Patient

Patient Name: ____ Date of Birth: ___________

Address: ____ Suite/Box: ________ City_____________

State ___________ Zip Code _____________ Phone: _______________ Alt# _______________

____

1. I am requesting that communication NOT be sent, given or received by any of the following methods:

Phone Calls or Answering Machines Faxes E-Mails Post Cards

____

2. I am giving permission to: _____________________________________, (please check relationship)

Grandparent Babysitter Non-Custodial Parent Other Relative

Other-specify: ____

to bring my child to De La Vega Pediatrics, Corp. for treatment, tests, medical procedures, in my absence. I am also giving permission for confidential health information to be disclosed to them as necessary, if I am unable to be contacted. Their

Telephone number is: ___________________________.

Note: Use one form for each person being given permission to bring child in and for each patient.

Description of the information to be used or disclosed *(check all that apply)*:

This is not a release of information form. Information will be used or disclosed per above instructions.

The entire medical record

Other/Specific Information:____

______________________________ __________________________

Parent or Guardian's Signature **Date**