Confidential Communication Form

Patient Name: _____ **Date of Birth:** _____

Primary Contact Number: _____ **Email Address:** _____

Preferred Methods of Communication

Communication Method	Preferences
Text Message	☐ Yes ☐ No
Phone Call	☐ Yes ☐ No
Email	☐ Yes ☐ No

Authorization to Leave Messages

Message Type	Authorized
Appointment Reminders	☐ Yes ☐ No
Test Results	☐ Yes ☐ No
Other healthcare info	☐ Yes ☐ No

Authorization to Discuss Healthcare with Other Individuals

Name	Relationship	Phone	Authorized For
			☐ Appointments ☐ Test Results ☐ Billing
			☐ Appointments ☐ Test Results ☐ Billing
			☐ Appointments ☐ Test Results ☐ Billing

Emergency Contact Name	Relationship	Phone

Acknowledgment: I understand that I may update or cancel these preferences at any time by providing written notice to Bee Well Pediatrics.

Parent or Guardian Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____