UCSF Benioff Children's Physicians

Detailed Messages Regarding Healthcare Information Form for Minors

You have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to leave detailed voice messages regarding your child's health information on an answering machine or other voice recording system. If you authorize UBCP providers and staff to leave detailed voice messages this authorization entitles; hospitals, provider offices, home health, etc. to leave detailed information, which may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. Detailed message authorization is optional and not a requirement. UBCP will only leave detailed messages regarding health information for the phone number authorized below and will not leave detailed messages at any other numbers in the record. The authorization to leave detailed voice messages will remain valid until withdrawn in writing, unless specified by a calendar date. **There are risks associated with leaving detailed voice messages regarding your child's health information, including, but not limited to, potential disclosure to a third-party. By signing this authorization form you acknowledge and accept the risks associated with this type of release. If your child's health information is disclosed to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.**

Additionally, you have the right to authorize UCSF Benioff Children's Physicians (UBCP) providers and staff to discuss your child's detailed medical information with designated individuals. Such detailed information may include medical diagnosis, surgical information, other healthcare services, test results, medication information and treatment of any illness or condition. This authorization is optional and not a requirement. The authorization to discuss your child's detailed medical information with designated individuals will remain valid until withdrawn in writing, unless specified by a calendar date. Please complete the UBCP Authorization for Release of Health Information Form to authorize designated individuals.

Patient Information	
(1) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(2) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	
(3) Patient Name (Last, First):	Date of Birth (DOB):
Date of 18th Birthday:	

Parent/Legal Guardian Information #1	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**
Parent/Legal Guardian Information #2	
Parent/Legal Guardian Name (Last, First):	
Date of Birth (DOB):	**Relationship to Patient:**

Today's Date (Date of Authorization):

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Phone Number(s) Authorized for Detailed Messages		
Phone Number	**Type**	**Parent/Legal Guardian**
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2
	☐ Home ☐ Cell ☐ Work	☐ #1 ☐ #2

NOTE: ***Expiration of authorization automatically occurs on the patient's 18th birthday.***

Specific Date(s) (Optional)	
From:	To:

Signature of Parent/Legal Guardian **Today's Date**

Signature of Parent/Legal Guardian **Today's Date**

Signature of Witness (required if patient/parent/legal guardian unable to sign) **Today's Date**

Relationship to Patient