PATIENT CONTACT FORM

Patient _____ DOB _____

I authorize APC to register my email address so that I may voluntarily have electronic access to view and manage my child's information, medical records, request prescriptions, etc Y N

At which of the following numbers do we have permission to contact you?

Y N Home _____
Y N Cell Phone (Carrier) _____
Y N Work _____
Y N Other _____

May we leave a message for you at work? Y N

May we leave a message for you at home? Y N

May we email and/or text you appointment reminders? Y N Email Address: _____

In addition to you and your insurance company, with whom may we discuss your child(ren)'s health information?

Y N	Your Spouse	Name/Telephone	_____
Y N	Child's Step Parent	Name/Telephone	_____
Y N	Caregiver	Name/Telephone	_____
Y N	Child's Grandparent	Name/Telephone	_____
Y N	Child's Babysitter	Name/Telephone	_____
Y N	Other Representative	Name/Telephone	_____

Do you have any health information that you would like to keep confidential from any person(s)? Y N
If so, please describe: _____

_____

May we fax your child(ren)'s shot record to his/her school if you verbally request us to do so? Y N
Name of School(s) _____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information and the opportunity to specify alternative means of communication of my protected health information.

I acknowledge that I have read and received a copy of the Privacy Notice.

_____ _____
Parent/Guardian/Representative Signature Date

_____ _____
Printed Name Relationship to Patient

For Office Use Only

We attempted to obtain the above information, but the information could not be obtained because:
( ) Individual refused to sign
( ) Communication barriers prohibited obtaining the information
( ) An emergency situation prevented us from obtaining the information
( ) Other (Please Specify)

_____

_____ _____ _____
Witness Signature Title Date