Patient Agreement for Communications

I _____, understand that as part of the health care of my child/children listed below

_____ _____

_____ _____

Cobb Pediatric Associates, PC will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow, etc. I hereby authorize *Cobb Pediatric Associates, PC* to contact me in the following ways:

(Check all that apply and provide numbers/e -mail addresses)

____ Home Phone:_____ Leave voice mail? ___ yes ___ no
____ Mobile Phone:_____ Leave voice mail? ___ yes ___ no
____ Office Phone:_____Leave voice mail? ___ yes ___ no
____ E-mail Address: _____
____ Fax: _____

My child's condition and medical information may be discussed with the following person(s) on my behalf:

1. Name/Relationship_____
2. Name/ Relationship_____
3. Name /Relationship_____

I understand that *Cobb Pediatric Associates, PC* will use the minimum necessary information needed when communicating indirectly. I understand that I have the right to revoke or amend this agreement at any time. Any revocation or change will not apply to any communications already completed. I understand that *Cobb Pediatric Associates, PC* will not share this information with any third party vendors or parties at any time.

Parent/Guardian's Signature Date