



Confidential Communication Preference

Date: _____

Patient Name: _____ Date of Birth: _____

Parent/Legal Guardian Name for Minor Patients: _____

Our current Notice of Privacy Practices allows us to call you with a courtesy reminder regarding upcoming appointments. In some cases it may become necessary to contact you by telephone to discuss other medical information. In the event that you are unavailable, we would like to be able to leave you a detailed message (e.g., lab results, x-rays, and other test results).

Please read the following choices and tell us whether or not we can leave a detailed message (e.g., lab results, x-rays, and other test results) on an answering machine and/or with any specific individuals you designate below.

Choose one of the following:

I consent and authorize to The Children's Clinic of Fredericksburg and it's staff to leave a telephone detailed message regarding my minor child at the following numbers (initial each phone number provided).

- | | | |
|--|-------|-----------------|
| <input type="checkbox"/> Home answering machine: | _____ | Initials: _____ |
| <input type="checkbox"/> Cell Phone: | _____ | Initials: _____ |
| <input type="checkbox"/> Work/Other Phone: | _____ | Initials: _____ |

I consent and authorize The Children's Clinic of Fredericksburg to disclose verbally any results or instructions to the following specified person(s) who are at least 18 years or older and may answer the above phone number(s) in my absence:

Designated Person Name: _____ **Relationship:** _____

Designated Person Name: _____ **Relationship:** _____

I do not consent or authorize detailed messages regarding medical care to be left on my answering machine or with a designated person. I wish to be contacted personally. I understand that there may be delays in receiving my results.

This communication preference will remain in effect until you rescind or provide a change.

Signature _____ Date _____