PediPlace
MAKING HEALTHCARE A REALITY FOR EVERY KID

502 S. Old Orchard Ste 126
Lewisville, TX 75067
972.436.7962

Communication Authorization for Personal Health Information

I authorize PediPlace to leave personal health information messages (including, but not limited to lab and other test results) for the patient listed. _____ ____/____/____
Patient Name DOB

Please tell us how you prefer to receive patient care reminders and medical information (appointments, medications, lab results, answers to questions) **Please circle one:** **Home phone** **Cell Phone** **Work Phone** **Home address** **Email** **Patient Portal**

Personal health information **messages** can be left at the following numbers:

Home phone (_____) _____-_____ Cell phone (_____) _____-_____

Work phone (_____) _____-_____

Personal health information can be **discussed** with the following people:

_____ _____
Name Name

Phone number we can text to pick up Rx-refills and forms and appointment reminders:

(_____) _____-_____
Cell Phone

Email for Patient Portal: _____@_____

You are responsible for notifying the office as quickly as possible if any of the above contact information changes. If you do not provide correct updated contact information in a timely manner your child's medical information could be sent to someone in error.

By signing below you authorize PediPlace to send medical information to your preferred contact method listed above.

_____
Print Name

_____
Signature Date

____I do not wish to receive patient care reminders and I will contact provider when I need to make an appointment or want medication refills

_____
Print Name

_____
Signature Date

This information will be requested annually for updates.

Fax: 972.420.0085