MIDWEST DERMATOLOGY

DEPENDENT PATIENT
CONTACT CONSENT FOR
PROTECTED HEALTH INFORMATION

Communication Preferences
(You have the right to revoke any information by completing a new form)

NAME OF DEPENDENT PATIENT_____AGE_____

NAME OF PARENT OR LEGAL GUARDIAN_____

WHAT IS YOUR RELATIONSHIP TO THIS PATIENT?_____

May we discuss the personal health information of this dependent patient with anyone else (such as other parent, stepparent, grandparent, adult child) etc?

- ❑ **YES**
- ❑ **NO**

IF YES, NAME OF OTHER PERSON_____

RELATIONSHIP TO PATIENT_____

When necessary, how do you prefer to be notified of Pathology, Laboratory or other test results or answers to your questions?

- ❑ Speak only to above named individuals personally? Y N

Your phone numbers:

Primary #_____ May we leave a message? Y N

Alt #1_____ May we leave a message? Y N

Alt #2_____ May we leave a message? Y N

(Your voice mail or answering machine greeting must be identifiable by name or phone number.)

Print Name of Parent or Legal Guardian_____

Signature of Parent or Legal Guardian_____Date_____

Relationship to patient_____

This consent will remain in effect until I choose to revoke it in writing.