Pediatric Consent to Leave Messages/Share Information with Family/ Friends

I understand that for Texas Pediatric Specialties & Family Sleep Center (TPS &FSC) to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give my permission to TPS & FSC.

Consent for Leaving Messages:

I give consent to TPS & FSC to leave a message on my voicemail/answering machine about my child's lab results. I understand that "sensitive information as noted below will be excluded.

☐ Yes ☐ No

Consent for shared information with Family & Friends:

The Name(s) listed below are family members or friends to whom I grant permission for my child's health care provider and their representatives at TPS & FSC to verbally discuss their care using their best judgement and grant them permission to disclose health information that is relevant to their care.

☐ Yes ☐ No

Under the HIPAA Privacy Law, we are permitted, and we may make a professional judgement that certain disclosures are in your best interest even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my/my child's protected healthcare information will be provided without my signature on a release of Information Form.

I understand that some information, as listed below, is considered "sensitive." I understand that I must check the specific boxes for my provider or his/her designee to release any "sensitive" information.

- Medical Conditions
- Mental Health/ Psychiatric disorders (including Depression)
- Chemical Dependency (Drug and/or alcohol abuse/treatment)
- Pregnancy Information

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Name (Please Print): _____ **DOB:** _____

Patient or Parent\Guardian Signature: _____ **Date:** _____

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