WESTERN WAKE PEDIATRICS

940 SE Cary Parkway, Suite 200
Cary, NC 27518
(919) 859-9991
fax (919) 859-6595

Adult Patient Contact & Authorization Form (Age 18+)

Now that you are 18 or older, privacy laws require that we communicate directly with you about your medical care. Please complete the information below to update your contact information and indicate who we may share information with.

_____ _____
Patient Name Date of Birth

_____
Preferred Phone Number

☐ This is my **personal cell phone**
☐ It is OK to leave:
☐ Voicemail messages
☐ Text messages (appointment reminders, results notification)

_____
Patient Email Address

Authorization to Share Medical Information
By law, we cannot share your medical information with anyone unless you give permission. Please list anyone you authorize our office to speak with about your medical care (for example: parent, guardian, or spouse).

This may include appointment information, lab/test results, and prescription information.

_____ _____ _____
Name Relationship Phone Number

☐ I do **NOT** authorize anyone to receive my medical information.

I understand that I may revoke this authorization at any time, but it will not apply to information already released. Information shared under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____
Patient Signature Date

Emergency Contact (not automatically authorized for medical information)

_____ _____ _____
Name Relationship Phone Number

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