Island Coast Pediatrics
Limitations and/or Restrictions of Protected Health Information
Regarding Communication and/or Care of the Patient over 18 years old

Patient Name: ____ Date of Birth: ___________________

Address: ____ Suite/Apt/Box: _________________

City: _________________________ State: ____ Zip: ________ Phone: ________________________

I am requesting that communication NOT be sent, given or received by any of the following methods:

☐ Phone Calls or Answering Machines ☐ Faxes ☐ Emails ☐ Post Cards

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I am giving permission to: ________________________________, (please check relationship)

☐ Parent ☐ Grandparent ☐ Sibling ☐ Other ____________________

☐ Other (please specify relationship): ____

to discuss my treatment with Island Coast Pediatrics. I am also giving permission for this individual to discuss and receive my Protected Health Information including, but not limited to: office notes, immunizations, appointments and prescriptions.

Above individual can be reached at (phone number): ______________________________

Note: Use one form per patient for each individual being given permission.

Description of the information I wish NOT to be used or disclosed to this individual ***(check all that apply)*****:** ***This is not a release of information form. Information will be used or disclosed per above instructions***

☐ Medical History ☐ Appointments ☐ Financial Statements ☐ Prescriptions ☐ Other: __________

_______________________________________ _____________________________

Patient's Signature ***(must be 18 at time of signature)*** Date

Note: This authorization form does NOT allow this person to request a copy of my medical records on my behalf.

Office Use Only:

Witnessed By: ____ on _______________

Communication Preference Noted in AllScripts By: ___________________________ on _______________

Information NOT to be Released Noted in AllScripts By: ________________________ on _______________

Request Sent to CBO for Scanning By: ____________________________________ on _______________