



Island Coast Pediatrics
Request for Limitations and /or Restrictions of Protected Health Information
Regarding Communication and/or Care of the Patient

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Suite/Box:** _____ **City** _____

State _____ **Zip Code** _____ **Phone:** _____ **Alt#** _____

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

- Phone Calls or Answering Machines
- Faxes
- E-Mails
- Post Cards

2. I am giving permission to: _____, (please check relationship)

____ Grandparent, ____ Babysitter, ____ Non-Custodial Parent, ____ Other Relative

Other-specify: _____

to bring my child to Island Coast Pediatrics for treatment in my absence. I am also giving permission for confidential health information to be disclosed to them as necessary, if I am unable to be contacted. Their

Telephone number is: _____.

Note: Use one form for each person being given permission to bring child in and for each patient.

Description of the information to be used or disclosed (*check all that apply*):

This is *not* a release of information form. Information will be used or disclosed per above instructions.

The entire medical record.

Other/Specific Information: _____

Parent or Guardian's Signature

Date

FOR OFFICE USE ONLY

Initial **Contact** for questions re form: _____ on _____

Form and **ALERT added to patient record** by: _____ on _____