
# Voice Mail Authorization

I give permission to Abington Pediatric Associates to communicate medical information such as laboratory and other test results about my child via the telephone number(s) provided. If an answering system is initiated, the practice is authorized to leave information related to the medical condition of my child on the machine.

I acknowledge that household members may potentially have access to these messages; however, I recognize that the risk of such incidental disclosure is minimal.

This authorization does not apply to the release of records related to psychotherapy, HIV or drug and alcohol testing, which are subject to more specific protection by state law.

I understand that I reserve the right to revoke this authorization at any time by contacting the practice. This authorization is solely for communications related to past, present, or ongoing treatment. Any authorizations required by HIPAA for the release of information to parties other than myself will necessitate a separate authorization form and are not included in this consent.