Rocky Hill Pediatrics

PERMISSION TO COMMUNICATE

Patient Name: _____ Date of Birth: _____/_____/_____

I authorize Rocky Hill Pediatrics to share my child's protected health information with family members or others as designated by me below. **This permission is NOT an authorization to release medical records, or a consent to treatment.** This permission authorizes Rocky Hill Pediatrics to communicate with the authorized persons by phone (including voice messages), in person or by HIPAA compliant e-mail.

RELEASE INFORMATION TO:

Name: _____

Relationship to patient: _____

Phone Number: _____

Name: _____

Relationship to patient: _____

Phone Number: _____

I understand that I am under no obligation to provide Rocky Hill Pediatrics with this Permission to Communicate, and that Rocky Hill Pediatrics will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form.
I understand that I may revoke this Permission if I choose so. I can revoke this Permission at any time by notifying Rocky Hill Pediatrics in writing. Communications should be sent to: Rocky Hill Pediatrics, 1084 Cromwell Avenue, Rocky Hill, CT 06067.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Patient or Guardian: _____

Date: _____

***Form expires one year after the date of signature**