Bright Pediatrics P.C. Privacy Officer : Joyce Hooker

Authorization for Use or Disclosure of Health Information

HOW CAN WE CONTACT YOU

(please circle yes or no)

Can we use your information to telephone or text you to remind or confirm an upcoming appointment? yes or no

Can we use your information to notify you of referral appointment dates and times? Yes or No

Can we leave messages regarding treatment and/or other information pertinent to your health care and/or payment for your healthcare provided at Bright Pediatrics P.C.? Yes or No

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WHO CAN WE SPEAK WITH OVER THE PHONE OR IN PERSON OUTSIDE OF AN APPOINTMENT?

Who can we discuss treatment and/or other information pertinent to your healthcare and/or payment For your healthcare provided at Bright Pediatrics P.C.?

Name of Authorized Person	Relationship to Child
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

* I understand that if the person or entity receiving Authorized Information is not a health care provider Covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal law.

*I understand that I may revoke this authorization at any time by notifying **Bright Pediatrics** in writing. However, if I choose to do so, I understand that my revocation will not reflect any actions taken by **Bright Pediatrics** before receiving my revocation.

**I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits

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Signature of parent or legal guardian Date