. Hilliard Pediatrics, Inc.

CONSENT FOR RELEASE OF INFORMATION

Patient Name: ____

Where are we allowed to attempt to contact you with test/lab results?

HOME: YES NO (please circle)

If yes, what is your HOME telephone number? _________________________________

WORK: YES NO (please circle)

If yes, what is your WORK telephone number? _________________________________

CELLPHONE: YES NO (please circle)

If yes, what is your CELL number? ____

PLEASE LIST FAMILY MEMBERS TO WHOM WE ARE PERMITTED TO GIVE TEST RESULTS:

Name and Relationship

____ __________

____

PLEASE LIST ANYONE WHO IS PERMITTED TO MAKE AND/OR BRING YOUR CHILD IN FOR APPOINTMENTS AND RECEIVE MEDICAL ADVICE. (OTHER THAN PARENT/: GUARDIAN)

Name and Relationship:

____

____

Many times when we call; we reach an ANSWERING MACHINE OR VOICEMAIL. Are we allowed to leave a detailed message with test results?

YES NO (please circle)

Print Parent/ Guardian Name___________________________________ Date_______________

Parent/Guardian Signature____

NOTE: Test results of a sensitive nature will ONLY be given directly to the parent/guardian