HIPAA Privacy and
Consent Form

I _____ give permission to the healthcare provider and their staff at Wee Care Pediatrics to leave messages regarding my healthcare in the following manner when I am not available:

**(Please mark all that apply)**

____ May **ONLY** leave information with me. **(If you check here, no other choices should be marked.)**

____ May leave appointment reminders on my answering machine/voice mail.

____ May leave appointment reminders with my family.*

____ May leave lab results on my answering machine/voice mail.

____ May leave lab results with my family.*

____ May leave general questions/information on my answering machine/voice mail.

____ May leave general questions/information with my family.*

* If any are checked above, please list name of individual we may give information to:

Name: _____ Relationship: _____

____ I prefer that all healthcare messages be given to the following person (family member, guardian, caretaker, or significant other):

Name: _____ Relationship: _____

I would prefer to be contacted at: _____ Home # _____

_____ Work # _____

_____ Cell # _____

_____ Other # _____

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____