Birmingham Pediatric Associates, Inc.

PATIENT CONTACT INFORMATION SHEET

*One form may be used for all children in the family **under age 14**; however, all children **14 years of age or older** must sign a separate form to allow their information to be disclosed to the contacts listed below.*

*Date: _____ >>>>> Is this an update to a previous **Patient Contact Information Sheet**? YES NO (circle one)*

Full Name of Patient: _____ Date of Birth: _____ Chart Number: _____

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Full Name of Patient: _____ Date of Birth: _____ Chart Number: _____

Any physician, staff, employee or representative of Birmingham Pediatric Associates, Inc. has my permission to discuss and/or disclose information regarding my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information in order to facilitate and coordinate my care, treatment and payment with the following persons:

Contact Name	Relationship to Patient	Phone Number(s)
Contact Name	Relationship to Patient	Phone Number(s)
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Any physician, staff, employee or representative of Birmingham Pediatric Associates, Inc. has my permission to discuss and/or disclose protected health information regarding "Blue Form" immunization records and doctor visit excuses for school absence when required by the patient's school. This information may be disclosed to the school by mail, fax or patient receipt and delivery and will not require any other special authorization beyond this form.

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. If I do not sign this form it is invalid and may not be used for contact information. I can revoke it by writing the Birmingham Pediatric Associates, Attn: Privacy Officer, 806 St Vincent's Drive, Suite 615, Birmingham AL 35205 or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s). I have been offered a copy of the Birmingham Pediatric Associates Notice of Privacy Practices and am aware of my responsibilities as well as Birmingham Pediatric Associates legal requirements and limitations as contained in the Notice of Privacy Practices.

- I acknowledge that I have received notification of the privacy practices of Birmingham Pediatric Associates, Inc.
- I understand that it is my responsibility to read the Notice of Privacy Practices fully.
- I was offered a written copy of the Notice of Privacy Practices on the date signed.
- If the signee is not the parent or legal guardian, signee agrees to forward this information to the parent or legal guardian.
- ***If the patient is 13 years of age or younger, the person who brings the patient must sign HERE:***

Signature: _____ Print Name: _____ Relationship to patient: _____

- ***Patients 14 years of age or older must sign this form BELOW.***

Signature of patient 14 years of age or older: _____ Print Name: _____

If any of the above information changes, please complete a new Patient Contact Information Sheet.