



# PATIENT APPROVED CONTACTS

**O**N this side of the form, you are able to designate trusted, reliable individuals that *you* authorize to bring your child in when you are unable to attend your child's appointment with their doctor.

PATIENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE NOTE: If any individual other than those listed below contacts English Road Pediatrics regarding the above named patient's personal health information, he or she will be referred back to the patient. In authorizing these individuals we will also assume that there are no limitations in communications regarding the patient.**

## CONTACT 1: (please print)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Contact Number (\_\_\_\_) \_\_\_\_-\_\_\_\_ Emergency Response Person: YES / NO

## CONTACT 2: (please print)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Contact Number (\_\_\_\_) \_\_\_\_-\_\_\_\_ Emergency Response Person: YES / NO

## CONTACT 3: (please print)

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Contact Number (\_\_\_\_) \_\_\_\_-\_\_\_\_ Emergency Response Person: YES / NO

Patient/

Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**IF signed by Representative, describe**

**authority to act on behalf of patient:** \_\_\_\_\_

**\*REMINDER:** As per FINANCIAL POLICY you've signed, regardless of legal arrangements regarding divorce situations, it is the policy of English Road Pediatrics & Adolescent Medicine that the parent or authorized individual who accompanies the child to the appointment is the responsible party for the day's co-pay in full. It is up to the parents to deal with their legal obligations amongst themselves.

## For Office Use Only

Expiration Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Expiration Event: \_\_\_\_\_

Date Request Filled: \_\_\_\_/\_\_\_\_/\_\_\_\_ By: \_\_\_\_\_

Information requested: \_\_\_\_\_ Account #: \_\_\_\_\_

Identification Presented: \_\_\_\_\_ Fee Collected: \_\_\_\_\_