CMU HEALTH
CENTRAL MICHIGAN UNIVERSITY

PATIENT COMMUNICATION FORM - MINOR

The purpose of the form is for you to document 1) if someone else may bring your child to the office for an appointment and 2) your preferences regarding who we can communicate with regarding your child.

SECTION ONE: I would like the following individual(s) to be able to bring my child to the office for routine care:

Name: _____ **Name:** _____

I understand the above person will NOT be able to consent for vaccinations or procedures unless I also complete the Parental Delegation of Authority Form. By consenting to allow the above individual to bring my child to the office for routine care, I am also authorizing CMU Medical Education Partners to verbally share protected health information during that visit only.

Parent/Legal Representative Signature: _____ **Signature Date:** _____

SECTION TWO:
Filling out the rest of this form will allow us to verbally message share information with the other individuals you specify or share information with the individuals listed above before or after the appointment they bring the child to. Any request to disclose written information, including but not limited to any information in your child's medical record, will only occur after a written authorization has been completed and signed. You may revoke this permission at any time by completing a new Patient Communication Form.

COMMUNICATIONS ABOUT MY CHILD

Telephone Contact# Home ( )_____ Cell ( ) _____
Preferred: Home ____ Cell____

If unable to reach me:
_____I give practice staff consent to identify themselves and leave verbal messages for me or to send text messages to me. I understand messages may include information and dates or future appointment or test results.

_____I do not give practice staff consent to identify themselves and leave messages for me.

COMMUNICATIONS WITH OTHERS

By signing below, I give permission for my child's care team to **discuss** my child's care (including diagnosis, diagnostic test results, examination information, claim information, and appointment confirmations) with the individuals specified below - if the individuals request information or if my care team believes it is in my best interest. This permission is specific to **my child's current treatment or care at any CMU Health location.**

(1) Name:_____ Relationship/Phone: _____

(2) Name:_____ Relationship/Phone: _____

(3) Name:_____ Relationship/Phone: _____

MAILINGS

_____ I **do** want to receive mailings from my doctor's office at my home address.
_____ I **do not** want to receive any mailings from my doctor's office at my home address. Please send them to my attention at:

_____

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I have carefully read and understood the information on this form. All my questions have been answered. I understand that the individuals listed above may continue to receive verbal communications regarding any information they request until I notify the office, in writing, of my decision to change it.

Minor Name (printed): _____Date of Birth: _____/_____/_____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____

EMERGENCY CONTACT
Name (print): _____ Relationship to Patient: _____ Cell: _____