Pediatric Patient Information and Communication Authorization

Patient's Legal Name: ______________________________ Date of Birth: ____________
First *Last* *Preferred Name* *mm/dd/yyyy*

Preferred Primary Contact *(This information will be on record as the primary phone numbers and address in the patient's chart. This information will be used for routine contact, such as confirmation calls, text messages, and paper mail.)*

Parent/Legal Guardian Name: ____________________ ____________________
First *Last*

Mailing Address: ____________________ ____________ ________ ______
Street *City* *State* *Zip*

Email Address: ____________________ **Relationship to patient:** ____________

Home phone: (_______) _______ - __________

Cell phone: (_______) _______ - __________

Work phone: (_______) _______ - __________

Secondary Contact *(Please list someone who has decision making authority on behalf of the patient. This information will be noted in the patient chart, but not used for routine contact such as confirmation calls & text messages.)*

Parent/Legal Guardian Name: ____________________ ____________________
First *Last*

Mailing Address: ____________________ ____________ ________ ______
Street *City* *State* *Zip*

Email Address: ____________________ **Relationship to patient:** ____________

Home phone: (_______) _______ - __________

Cell phone: (_______) _______ - __________

Work phone: (_______) _______ - __________

Communication Authorization: You may specify up to three individuals authorized to receive routine verbal communication about your child's healthcare (prescription requests, referral requests, requesting a new appointment, requesting changes to an appointment, and medical inquiries/status updates). Please provide the first and last names of the individuals you authorize us to communicate with.
*This authorization does not include communication about mental health treatment.

1. **Name:** ____________________ **Relationship to Patient:** ____________________
2. **Name:** ____________________ **Relationship to Patient:** ____________________
3. **Name:** ____________________ **Relationship to Patient:** ____________________

This information and communication authorization will remain active for 12 months, at which time I will be given an opportunity to confirm or update. I understand I have the right to revoke these preferences in writing at any time. I understand that I will need to complete InterMed's Authorization to Release Health Care Information form or provide an equivalent HIPAA compliant authorization if I wish to allow my provider to discuss health information not covered by the categories listed above. Disclosure of mental health treatment status requires execution of InterMed's Release of Information.

______________________________ ____________
Parent / Legal Guardian Signature *Date: mm/dd/yyyy*

Version: 05/07/2024

UPON INSTRUCTION ONLY:

Confirmation that above authorization remains in place for the next 12 months:

Patient / Legal Guardian Signature:	**Year:**

Version: 05/07/2024

InterMed Consent to Treat

Patient's Legal Name: ____ Date of Birth: ________________

First *Last* *mm/dd/yyyy*

I consent to routine medical treatment and/or evaluation including but not limited to surgery, laboratory, pharmacy and x-ray examinations. I understand that separate consents will be requested for certain special procedures. I also understand I have the right to refuse any proposed procedure or treatment. Treatment may be face-to-face, or I may choose to receive telehealth services via a secure, web-based platform.

This authorization will remain current until an updated version is received, or this version is revoked in writing. I understand I have the right to revoke this authorization in writing at any time.

____ ______________________

Patient / Legal Guardian Signature *Date: mm/dd/yyyy*

Version: 05/07/2024