Patient's Name: ____

Patient's Date of Birth: _________________________________

Consent to Contact

The providers and staff at Family Care Southwest may, at times, need to contact you about your minor child's healthcare. In accordance with HIPAA guidelines, please indicate below how you would like to be contacted: (check all that apply)

____ FCSW Portal message ____ US mail ____ Primary Telephone Number: ______________________________

May we leave a voice mail message containing personal health information at the above telephone number?
____ Yes ____No

____ Secondary Telephone Number: ____

May we leave a voice mail message containing personal health information at the above telephone number?
____ Yes ____No

By supplying my primary phone number, email address and any other personal contact information, I authorize Family Care Southwest to employ a third-party automated outreach and messaging system to use my minor child's personal information, the name of my minor child's care provider, the time and place of my minor child's scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due and collections, lab results or any other healthcare-related function. I also consent to receive messages from my healthcare provider(s) when necessary.

Parent's/Guardian's Initials _______
(By initialing, you are acknowledging that you have read and understand the above consent.)

Authorization to Contact Others

Family Care Southwest has my authorization to contact or release any and/or all of my minor child's protected health information to the following individual(s). This may include authorization to pick up test results, sample medications, medical records or discuss medical conditions, care plans or billing matters. I understand that the individual(s) listed below may be required to provide proof of identity before any medical information can be released. I understand that if this area is left blank, Family Care Southwest is not authorized to release any protected health information in accordance with the HIPAA Privacy Rule.

Name: ____

Relationship to Patient: ____

Primary Telephone Number: ____________________________________

May we leave a voice mail message containing personal health information at the above telephone number?
____ Yes ____No

Name: ____

Relationship to Patient: ____

Primary Telephone Number: ____________________________________

May we leave a voice mail message containing personal health information at the above telephone number?
____ Yes ____No

By initialing below, I authorize Family Care Southwest to release any information specified below to the person(s) listed previously. If the categories below are not initialed, I understand that Family Care Southwest will not release any of the information listed.

I specifically authorize the release of information regarding the following condition(s):

Initials	Initials	Initials
____ Drug Abuse (if any)	____ Substance abuse (if any)	____ Sexual health
____ Psychological/Psychiatric (if any)	____ AIDS/HIV (if any)	

If you have any restrictions on any specific protected health information, please designate below:

____

This authorization will expire in one year and must be renewed annually.

When my information is used or disclosed pursuant through this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Family Care Southwest has acted in reliance upon this authorization. My written revocation must be submitted to ***Family Care Southwest, P.C., 6169 S Balsam Way, Suite 250, Littleton, CO 80123***.