Permission to communicate (Minor)

☐ By checking this box, I am revoking all previous Permission to Communicate forms.

Minor Child's Name: _____ Date of Birth:_____

I, _____ authorize Sunshine Pediatrics to communicate my minor child's private health information with family members or others involved in my child's care as designated below. This permission is NOT an authorization to release medical records or consent to treatment.

This permission also authorizes Sunshine Pediatrics to communicate with the authorized persons by phone (including voice messages), in person, or by other means acceptable to Sunshine Pediatrics.

Name:	
Phone Number:	Relationship to Patient:
Name:	
Phone Number:	Relationship to Patient:
Name:	
Phone Number:	Relationship to Patient:

I understand that I am under no obligation to provide Sunshine Pediatrics with this Permission
to Communicate, and that Sunshine Pediatrics Providers will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form.
I understand that I may revoke this Permission if I so choose. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form, or by notifying Sunshine Pediatrics Physicians in writing of my revocation.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Parent/Guardian: _____ Date: _____

Office Use Only: Administrative: HIPAA: Permission to Communicate MRN_____