CONSENT TO LEAVE MEDICAL INFORMATION BY PHONE OR EMAIL

I (PLEASE CIRCLE PREFERENCE) DO OR DO NOT GIVE NIGHT AND DAY PEDIATRIC STAFF PERMISSION TO LEAVE PHONE OR EMAIL MESSAGES WITH MEDICAL INFORMATION PERTAINING TO MY CHILD,

_____.
(NAME AND DOB OF PATIENT)

I WILL NOT HOLD NIGHT AND DAY PEDIATRIC STAFF LIABLE FOR ANY INFORMATION THAT IS OVERHEARD OR READ BY ANY UNAUTHORIZED PARTY.

NAME OF PERSON AUTHORIZING_____

RELATIONSHIP TO PATIENT_____

DATE_____

PHONE NUMBER AUTHORIZED RECEIVE MEDICAL INFORMATION WITH AREA CODE:

_____

EMAIL ADRESS AUTHORIZED TO RECEIVE MEDICAL INFORMATION:

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