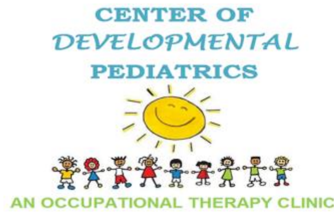


RELEASE OF INFORMATION

As Parent/Legal Guardian, I grant the Center of Developmental Pediatrics (CDP) permission to release information regarding my child, ________________________________ to the following professionals:

Pediatrician: Name: ____
Address: ____
City, State, & Zip: ____
Phone #: ____

School: Name: ____
Address: ____
City, State, & Zip: ____
Phone #: ____

Other (Family members/caregivers, doctors, therapists, tutors, etc.):
Name: ____
Address: ____
City, State, & Zip: ____
Phone #: ____
Relationship to patient: ______________________________________

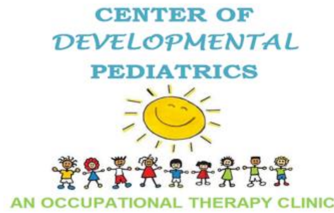
Name: ____
Address: ____
City, State, & Zip: ____
Phone #: ____
Relationship to patient: ______________________________________

Name: ____
Address: ____
City, State, & Zip: ____
Phone #: ____
Relationship to patient: ______________________________________

This ***Release of Information*** will remain in effect until terminated by me in writing.

Printed Name: ____ Date: ________________________

Signature: ____ Relationship to child: ___________



COMMUNICATION AND MESSAGES AGREEMENT

Patient Name: ____

Address: ____

Date of Birth: _______________

As allowed by the "Privacy Regulations," I authorize Center of Developmental Pediatrics to provide the following "Alternative" means of communicating my Protected Health Information:

- ☐ Phone ____________________________________
- ☐ Text Messages ____________________________________
- ☐ Email ____________________________________

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call

The best time to reach me is (day) _______________________ between (time) ______________.

This ***Communication/Messages Agreement*** will remain in effect until terminated by me in writing.

Printed Name: ____ Date: ________________________

Signature: ____ Relationship to child: ___________