



Child's Name: _____

Date of Birth: _____

In an effort to ensure your privacy, it is important for us to understand your preferred method of receiving and communicating medical and administrative information pertaining to your child's therapy. As such, please indicate your communication preferences below.

For medical and administrative information pertaining to my child such as clinical documentation, appointment reminders, therapy updates, etc. I hereby grant permission to Bloom Pediatric Therapy to do the following:

Written Documentation and Verbal Information

- I grant permission to provide me with written communication via HIPAA compliant encrypted email service via my email address provided.

- I grant permission to provide me with written communication (such as appointment reminders or cancellations) via text message at the cell phone number provided. I understand that with this option, written communication may be viewed by an unintended third party and I fully accept this risk.

- I grant permission to provide me with written communication via USPS in an unmarked envelope.

- I elect to receive clinical information in person or via telephone through the number provided.

- I grant permission to leave relevant medical information on my answering machine or voicemail at the number provided.

- I grant permission to release medical information pertaining to the child to the individuals listed below:

Sharing of Information

Individual's Name	Relationship to Child	Email Address and/or Phone Number
1. _____		
2. _____		

I understand that it is my responsibility to inform the practice of changes to my preferred contact information or my communication preferences, as well as to revoke this authorization at any time.

Print Name of Child

Date

Signature of Parent or Legal Representative

Relationship to Child