

Communication Permissions - Minor

Patient Name: _____ **Date of Birth:** _____

SECTION 1

Biological or legal parents or guardian(s) contact information <i>(please provide proof if legal guardian, legal representative, medical power of attorney, etc.):</i>	
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone: _____	Phone: _____
<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other: _____	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other: _____

SECTION 2

Mosaic may leave a voicemail for the following reasons using the above numbers: (check all that apply)
<input type="checkbox"/> Medical Information <input type="checkbox"/> Billing <input type="checkbox"/> Automated Appointment Reminders <input type="checkbox"/> No Messages of any kind Use: <input type="checkbox"/> Preferred Number on file ONLY <input type="checkbox"/> Any Personal Number on file (not including emergency contact)

SECTION 3

Patient Contact Information <i>(if applicable). Patients who are minors (Under age 18) may request certain levels of confidentiality and consent to various health care matters depending on their age. Further details regarding this can be provided by Mosaic Staff.</i>
Patient's Phone Number: _____ <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other: _____ Mosaic may <i>(please check all that apply):</i> 1. Leave medical information on voicemail: <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Use for automated appointment reminders*: <input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION 4

Please complete this section if there is anyone besides the parent/guardian that may regularly seek and authorize medical care for the patient AND/OR with whom a Mosaic representative may share healthcare information about the patient [step parents, grandparents, etc. <i>(NOTE: This is not an authorization to release medical records.)</i>]
<input type="checkbox"/> None Name: _____ Relationship: _____ Phone: _____ Regarding: <i>(please check all that apply)</i> <input type="checkbox"/> Schedule or cancel appointments <input type="checkbox"/> All Information <input type="checkbox"/> Seek medical care <input type="checkbox"/> Other: _____ Name: _____ Relationship: _____ Phone: _____ Regarding: <i>(please check all that apply)</i> <input type="checkbox"/> Schedule or cancel appointments <input type="checkbox"/> All Information <input type="checkbox"/> Seek medical care <input type="checkbox"/> Other: _____

SECTION 5

Signature required
<p><i>This authorization may be changed or revoked in writing at any time, it will remain in effect until that time or the patient turns 18.</i></p> <p><i>By signing below, I acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.</i></p> <p>Signature (Parent/Legal Guardian): _____ Date: _____</p> <p>Print name (Parent/Legal Guardian): _____ Relationship: _____</p>