Wheaton Pediatrics
A helpful hand in your child's future.

HIPAA Form
PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE FORM

Patient #1 _____ **DOB** ___ / ___ / ___
Patient #2 _____ **DOB** ___ / ___ / ___
Patient #3 _____ **DOB** ___ / ___ / ___
Patient #4 _____ **DOB** ___ / ___ / ___
Patient #5 _____ **DOB** ___ / ___ / ___
Patient #6 _____ **DOB** ___ / ___ / ___

Authorized Methods of Communication (Please check all that apply)

Primary Contact Information:

Name: _____ Relationship to Child: _____

Please choose one: ☐ Biological Parent ☐ Step Parent ☐ Legal Guardian ☐ Other: _____

Residence Phone #: _____ ☐ No Message ☐ Detailed Message ☐ Call Back # Only

Cellular Phone #: _____ ☐ No Message ☐ Detailed Message ☐ Call Back # Only

Work Phone #: _____ Ext: ____ ☐ No Message ☐ Detailed Message ☐ Call Back # Only

E-mail Address: _____ *Note: Wheaton Pediatrics will not e-mail medical records

Secondary Contact Information:

Name: _____ Relationship to Child: _____

Please choose one: ☐ Biological Parent ☐ Step Parent ☐ Legal Guardian ☐ Other: _____

Residence Phone #: _____ ☐ No Message ☐ Detailed Message ☐ Call Back # Only

Cellular Phone #: _____ ☐ No Message ☐ Detailed Message ☐ Call Back # Only

Work Phone #: _____ Ext: ____ ☐ No Message ☐ Detailed Message ☐ Call Back # Only

E-mail Address: _____ *Note: Wheaton Pediatrics will not e-mail medical records

Consent to Release Information

Please list below any person (s) whom you would like us to release information to other than those listed above upon their request. *Please note that Wheaton Pediatrics will release requested medical information with the exception of information that is excluded by the law to the following individual(s):

Name _____ Relationship to Patient _____ Phone Number _____

Name _____ Relationship to Patient _____ Phone Number _____

Name _____ Relationship to Patient _____ Phone Number _____

Emergency Contacts

Nearest relative not living with you: _____ Relationship to Patient: _____ Phone Number _____

In case of an emergency, please notify: _____ Relationship to Patient: _____ Phone Number _____

If above cannot be reached, please contact: _____ Phone Number _____

Please note that the above information will remain valid unless otherwise specified. Please notify the Wheaton Pediatrics, Ltd. staff of any changes.

Parent or Patient Signature: _____ **Date:** _____

For Office Use Only
Account No:

HIPAA 2.2012