

VALLEY PEDIATRIC ASSOCIATES, L.L.C.

Patient confidentiality is a top priority at Valley Pediatrics. Therefore, it is important that parents or patients over 18 years old age provide us with the following information to ensure there is no privacy violation. The following people have permission to approve treatment for your child.

Please name all persons and places where we may leave health information, including return phone messages, lab and test results, and scheduling reminders.

PATIENT NAME(S): _____ DOB: _____
 _____ DOB: _____
 _____ DOB: _____
 _____ DOB: _____

Please indicate the preferred NUMBER to contact you for: (number 1, 2, 3)	Appt Reminder	Test Results
MOTHER'S NAME:		
Email		
Home Phone		
Cell Phone		
Work Phone		
FATHER'S NAME:		
Email		
Home Phone		
Cell Phone		
Work Phone		
OTHER (Name & Relationship):		
Email		
Home Phone		
Cell Phone		
Work Phone		
OTHER (Name & Relationship):		
Email		
Home Phone		
Cell Phone		
Work Phone		

In understand that if the status of any of the above information changes it will be the responsibility to inform the staff of Valley Pediatrics.

Parent / guardian: _____ Dates: _____