☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic

AUTHORIZATION TO SHARE PATIENT INFORMATION - PEDIATRICS

Patient Name:____
LAST FIRST MIDDLE

Date of Birth: ______________________________

Phone Messages

Is there a phone number where the Hoag entity selected above and affiliates can leave **detailed** messages regarding your child's care, appointment/health screening reminders and other health care messages?

☐ Yes ☐ No If yes, please provide phone number: ____________________________________

Text Messages

Do you wish to receive appointment/health screening reminders and other health care messages via text regarding your child?

☐ Yes ☐ No

If yes, please provide preferred phone number to receive text messages: ________________________________

E-Mail

Do you wish to receive appointment/health screening reminders and other health care messages via e-mail regarding your child?

☐ Yes ☐ No

If yes, please provide preferred e-mail address: ____

Additional Contact

Is there someone else who the Hoag entity selected above and affiliates can leave **detailed** messages with and share your child's patient information?

☐ Yes ☐ No

If yes, please provide:

Name:_____________________________________ Relationship to Patient: ________________________

Phone Number: ______________________________

I hereby consent to receiving messages regarding my child, as indicated above, from the Hoag entity selected above and affiliates. These parties may use the provided information to contact me by e-mail, live agent, voice mail, text message or pre-recorded message, including by using an auto-dialer or other computer assisted technology, or by any other electronic communication for purposes that include appointment and follow-up health care reminders, pre-registration, surveys, prescription information, health-related products or services that may be of interest, my account(s), assignment of benefits, and financial responsibility. I understand that depending on my phone plan, I could be charged for these calls or text messages. I also understand that providing this contact information and consent are not conditions to my child receiving health care services. With respect to text messages, I understand that I can opt-out at any time by replying "STOP" to the text message from my mobile device.

The Authorization to Share Patient Information remains in effect until a request to withdraw from this form is submitted in writing by the patient or the patient's legal representative.

Patient/Legal Representative Signature: ________________________________ Date/Time: _______________

If signed by other than patient, indicate relationship: ____

Print Name – Legal Representative: ____

PATIENT LABEL