Royal
KIDS
Pediatric Clinic

AUTHORIZATION TO SHARE PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____

Phone Messages
Is there a phone number where ROYALKIDS CLINIC providers/staff can leave 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:
_____

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Emergency Contact
Is there someone else who ROYALKIDS CLINIC can leave a message with?

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 ROYALKIDS CLINIC. ROYALKIDS CLINIC 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 (Print Name):_____
Patient/Legal Representative Signature: _____
Date: _____Time:_____AM/PM
If signed by other than patient, indicate relationship to patient:_____
Witness: _____ Date:_____Time: _____AM/PM