Rocky Hill Pediatrics

1084 Cromwell Ave. Rocky Hill, CT 06067 Office: 860.721.7561 Fax: 860.721.9199

HIPAA PRIVACY PATIENT COMMUNICATION FORM

It is the office policy of Rocky Hill Pediatrics, LLC not to release confidential medical information regarding your child's treatment to family members except when the child is escorted by a relative/caretaker and/or another adult to their visit. By signing below, you agree to allow us to communicate with who accompanies your child at their visit. If you anticipate that you will need or want your medical information to be provided to other family members, caretakers, school personnel, or other medical providers/specialists, please specify below.

By signing below, you authorize the following people to receive information regarding your child's treatment or care. Parents are automatic, unless noted otherwise.

Signature is valid for one year from date of this form.

Child's Name: _____ ***Date of Birth***: _____

Parent's Name: _____

Parent's Signature: _____ ***Date:*** ___/____/____

NAME: _____

*PHONE NUMBER:*_____

*RELATIONSHIP TO CHILD:*_____

NAME: _____

PHONE NUMBER: _____

RELATIONSHIP TO CHILD: _____