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

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 most current Authorization to Share Patient Information is the active authorization and remains in effect until a new Authorization to Share Patient Information is completed.

Patient/Legal Representative Signature: _____ Date/Time: _____

If signed by other than patient, indicate relationship: _____

Print Name – Legal Representative: _____

PATIENT LABEL