Shodair Children's Hospital

Department of Medical Genetics
Phone 406-444-1016 | Fax 406-444-1064
www.shodair.org | 2755 Colonial Drive | Helena, MT 59601

Abdallah Elias, MD, FAAP, FACMG
Chief Medical Officer/Laboratory Director

Jaclyn Haven, MS, LCGC
Lead Genetic Counselor

Corbin Schwanke
Chief Administrative Officer

Willow Sheehan, DNP, APRN, FNP-C

Katherine Berry, MS, LCGC

Tyler Setlock, RD

Christa Smelko, PsyD

Caitlyn Patera, BSN, RN

## Patient Information:

Last Name _____

First Name _____

Middle Initial _____

Birth Date _____

Social Security # _____

Sex Assigned at Birth: ☐ Male ☐ Female ☐ _____

Gender Identity: ☐ Male ☐ Female ☐ Non-binary ☐ _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____

Email Address _____

## Legal Guardian(s) (Complete for Minors)

Name _____

Birth Date _____ Relationship to Patient _____

Name _____

Birth Date _____ Relationship to Patient _____

Are there any custody arrangements or family circumstances that we should be aware of? If so, please explain. If there is a parenting plan in place, please provide a copy.

## General Information

Primary Care Physician _____

Phone / Clinic _____

Preferred Language _____

Needs Interpreter ☐ Yes ☐ No

Marital Status _____

Employer _____

Employment Status _____

***Ethnicity - Check all that apply***

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

***Race - Check all that apply***

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Other
☐ Unknown
☐ White or Caucasian

## Emergency Contact (For Patients 18+)

Name _____

Phone Number _____

Relationship to Patient _____

*If child resides in **foster care** please complete the following:*

Case Worker Name _____ Mailing Address _____

Phone # _____ City/State/Zip _____

Foster Parent(s) _____ Phone # (Foster) _____

***~Please provide legal documentation of medical consent and guardianship for patient~***

## SECTION 3: INSURANCE INFORMATION (fill out completely & provide a copy of insurance card if possible)

Primary Insurance Co. Name _____

Name of Subscriber _____ Date of Birth of Subscriber _____

Social Security # of Subscriber _____ ID # _____ Group # _____

Secondary Insurance _____

Name of Subscriber _____ Date of Birth of Subscriber _____

Social Security # of Subscriber _____ ID # _____ Group # _____

Form Completed By _____ Date _____

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# History Questionnaire/Review of Systems

**NAME:** _____ ☐Male ☐Female DOB: _____

*Please check all that apply:*

**Any history of:** (Constitutional symptoms)
- ☐ Developmental delay
- ☐ Change in weight
- ☐ School difficulties

**Do you have:** (Skin)
- ☐ Unusual healing
- ☐ Spots (brown, white, red)
- ☐ Bumps

**Have you recently had:** (All/mm)
- ☐ Severe allergies
- ☐ Frequent infections

**Have you recently had:** (ear/nose/mouth/throat)
- ☐ Hearing loss
- ☐ Difficulty swallowing/reflux
- ☐ Difficulty sleeping
- ☐ Snoring

**Do or have you had:** (eyes/head)
- ☐ Visual problems
- ☐ Severe headache
- ☐ Small head
- ☐ Large head

**Do you have:** (respiratory)
- ☐ Shortness of breath
- ☐ Frequent coughs
- ☐ Wheezing

**Do you have:** (CV)
- ☐ Chest pain
- ☐ Murmur
- ☐ Congenital heart defect

**Do you have:** (GI)
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Diarrhea
- ☐ Constipation

**Do you have:** (GU)
- ☐ Problems with urination
- ☐ Genital birth defects
- ☐ Urine infections
- ☐ Menstruation (if applicable)
- ☐ Irregular periods (if applicable)

**Do you have:** (endo)
- ☐ Thyroid problems
- ☐ Absent body hair
- ☐ Excess body hair
- ☐ Unusual body odor

**Do you have any other signs, symptoms, or problems other than above?**
- ☐ No
- ☐ Yes, please explain:

**Do you have:** (musculoskeletal)
- ☐ Loose joints
- ☐ Pain in joints
- ☐ Stiffness
- ☐ Scoliosis
- ☐ Broken bones
- ☐ Muscle weakness

**Do you have:** (Neuro)
- ☐ Attention problems
- ☐ Speech problems
- ☐ Seizures
- ☐ Balance problems

**Do you have:** (Psych)
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Problems with drugs/alcohol

**Do you have:** (Heme/Lymph)
- ☐ Bruise easily
- ☐ Bleeding problems
- ☐ Puffy hands/feet

Signature (patient or parent/guardian):_____ Date:_____

# NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how Shodair may use and disclosure your protected health information to carry out treatment, payment, or health care operations and for other purposes permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you including demographic information that may identify you and that relates to your past, present, or future physical or mental health and related health care services.

## YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of Shodair Hospital, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your protected health information. Shodair Hospital will honor your request for restrictions to the extent possible but is not required to agree to the request.
- Obtain a paper copy of the Notice of Privacy Practices upon request.
- Inspect and obtain a copy of your protected health information and billing information upon written request within 30 days of the request.
- Information held electronically will be provided in electronic form if requested by the patient and if it is readily producible in electronic form.
- Request amendment of your protected health information and billing information in writing.
- Obtain an accounting of disclosures of your protected health information upon written request.
- Request confidential communication of your protected health information by alternative means or at alternative locations.
- At any time revoke in writing your authorization to use or disclose protected health information except to the extent that action has already been taken in reliance on the authorization or as otherwise limited by law.
- Our patients have a right to a restriction to disclosure of PHI to a health plan for payment if the patient has paid in full for the services and items provided in that visit.
- Our patients have the right to agree or object to participation in a facility directory. **Note:** Shodair does not utilize a facility directory.
- Our patients have the right to agree or object to the disclosure of protected health information to a family member, legal guardian, or close personal friend of the patient, to the extent the protected health information is relevant to the individual's involvement in the patient's care or payment related to that care. If the patient is not able to agree or object due to the patient's incapacity or an emergency circumstance, health professionals, using their best judgment, will decide whether a limited disclosure related to the individual's care of the patient is in the best interests of the patient.

## SHODAIR HOSPITAL IS REQUIRED TO

- Maintain the privacy of your protected health information.
- Provide you with a notice as to our legal duties and our privacy and security practices with respect to protected health information we collect and maintain about you.
- Abide by the terms of our Notice of Privacy Practices.
- Notify you if we agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate confidential protected health information by alternative means or at alternative locations.
- Obtain your written authorization to use or disclose your protected health information in situations other than those described in this notice or otherwise authorized by law.
- Notify you in case of a breach of your unsecured protected health information when it has been or is reasonably believed to have been accessed, acquired, used or disclosed in violation of privacy or security regulations.

*Shodair Hospital reserves the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will place copy of the current notice in the hospital. The notice will contain the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services, we will offer you a copy of the current notice in effect. Shodair Hospital may also revise its policy and procedures regarding the use and disclosure of protected health information at any time, which could subsequently result in additional uses or disclosures that would not require an individual's authorization.*

## USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Shodair Hospital may use and disclose your protected health information without authorization for certain purposes, such as treatment, payment and health care operations. The following examples of these uses and disclosures are not meant to be exhaustive, but are included to give you an idea of when your protected health information could be disclosed.

**Shodair Hospital will use your health information for treatment.** For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of your treatment. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. Shodair Hospital will also provide your physician or subsequent healthcare provider with copies of various reports that will assist him or her in treating you once you are discharged.

**Shodair Hospital will use your health information for payment**. For example, Shodair will send a bill to you and/or your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. Information can be disclosed to a plan sponsor for plan administration. Genetic information cannot be used to decide whether coverage can be given or at what price.

**Shodair Hospital will use your health information for regular health care operations.** For example, members of the medical staff or the departments that provided your care may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

**Shodair Hospital will use your health information for treatment, payment and health operations of other covered entities.** For example, we may release information to your physician so that he or she may send a bill to you and/or your insurance company. In addition, Shodair may provide your physician or referring hospital with information required to perform quality improvement, peer review, compliance review and medical education.

## OTHER USES AND DISCLOSURES

Shodair Hospital may also use and disclosure your protected health information without authorization for the following purposes:

**Abuse or Neglect:** We may disclose your protected health information to a public health agency authorized by law to receive reports of child abuse or neglect. In addition, we may disclose protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to a governmental entity or agency authorized to receive such information. In this case, the disclosure is made consistent with the requirements of applicable federal and state laws.

**Business Associates:** There are some services provided in our organization through contracts with business associates. For example, we may release information to an organization that processes billing claims electronically for our business office. When these services are contracted, we may disclose your protected health information to the business associate so that they can perform the job we've asked them to do and bill you or your insurance company for services rendered. To protect your health information, we require the business associate to appropriately safeguard your information.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Communicating appointment reminders and health care alternatives:** We may contact you to provide appointment reminders or provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Coroners, Funeral Directors:** We may disclose protected health information to coroners or medical examiners for identification purposes to determine cause of death, or for the performance of other duties as authorized by law. We may also disclosure protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

**Food and Drug Administration (FDA):** We may disclose your protected health information to a person or company required by the FDA to report .adverse events, product defects or biologic product deviations; to track FDA- regulated products; to enable product recalls, repairs, replacement or to locate and tell individuals about recalled or withdrawn products; or to conduct post-marketing surveillance.

**Fundraising:** We may contact you as part of our fundraising efforts, or your name and address may be used to send you a newsletter about our services. We may also contact you to request a tax deductible contribution to support important activities at Shodair Hospital. In connection with any fundraising, we may disclose to our fundraising staff, your name, address, age, gender, date of birth, the hospital program providing services, your provider's name, and the days when you received care here. You may opt out of any fundraising activity and Shodair Hospital will not condition treatment or payment on whether an individual opts out of a fundraising activity.

**Marketing:** We may use or disclose your health information to identify health-related services and products that may be beneficial to your health and we may contact you about these services and procedures. [All marketing requires an authorization, except face-to-face communication or a promotional gift of a nominal value].

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Law Enforcement:** We may disclose your protected health information to law enforcement if (1) you are a victim of a crime; (2) it is required by law: (3) it is necessary to identify and locate a suspect, fugitive, witness, or missing person; (4) the protected health information constitutes evidence of criminal conduct that occurred on Shodair Hospital's premises; (5) a death occurs as a result of a crime; or (6) there is a medical emergency (not on Shodair Hospital's premises) and it is likely that a crime has occurred.

**Legal Proceedings:** We may disclose protected health information during any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (if such a disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request or other lawful process.

**Organ Procurement:** Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Public Health:** As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Psychotherapy Notes:** Shodair will disclose psychotherapy notes only if Shodair has received an authorization, except in limited cases involving treatment, payment, or health care operations.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and protocols to ensure the privacy of your protected health information.

**Sale of Protected Health Information:** Shodair must obtain an authorization before selling any protected health information.

**Threat to Public:** We may disclose your protected health information if it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Workers' Compensation:** We may disclose your protected health information to comply with laws relating to Workers-' Compensation or other similar programs established by law.

**Other Uses:** Shodair will obtain your authorization for any use or disclosure of protected health information not described in this Notice.

If you have any questions about this notice, please contact our Privacy Officer at (406)444-7540. If you believe your privacy rights have been violated, you can contact our Privacy Officer at the above number for information about how to file a complaint. You may also file a complaint with the Secretary of Health and Human Services. Shodair Hospital prohibits retaliation against any individual filing a privacy complaint.

EFFECTIVE DATE: *August 8, 2016*

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**Department of Medical Genetics**
2755 Colonial Drive
P.O. Box 5539
Helena, MT 59604
Phone: 406-444-7500
Fax: 406-444-1064

## Acknowledgment of Receipt of Notice of Privacy Practices

I understand that Shodair Hospital may share my health information for treatment, payment and healthcare operations. I have been given a copy of Shodair Hospital's Notice of Privacy Practices that describes how my health information is used and shared. I understand Shodair Hospital has the right to change this notice at any time. I may obtain a current copy by contacting Shodair Hospital.

My signature below constitutes my acknowledgment that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Representative Date

If signed by Legal Representative, relationship

to patient: _____

Patient Name: _____ Date of Birth: _____

This authorization will remain valid for a period of 12 (twelve) months from the date of signature unless revoked by me before that time. This authorization may be revoked by sending such revocation in writing to the HIM Director at 2755 Colonial Drive, Helena, MT 59601. Shodair will comply with the revocation unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization.

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Patient Name: _____ DOB: _____

**AUTHORIZATION FOR TREATMENT AND PAYMENT AGREEMENT**

I hereby authorize the physician or physicians in charge of the care of the above patient to administer any outpatient treatment necessary or advisable in evaluation, diagnosis, and care of this patient. I understand that the physician may discover other or different conditions that require additional or different treatment than that currently anticipated. I authorize the physician and such other health care providers to administer such other treatment that is necessary or advisable in their professional judgment.

Shodair Children's Hospital staff care about the quality of service we provide to patients and families. Please provide us with your insurance information, be it private or through a government agency, and we would be glad to assist you in determining any financial obligations you might incur during the patient's treatment. If the patient is not covered by an insurance program, then our staff will provide you with information about other potential options that might exist, such as our program called ShoCare. If you qualify, this program provides financial assistance in the form of discounts and monthly interest-free payments. Our Financial Counselor will send you a program brochure with the first billing statement. Or you may request a brochure at any time by calling 406-444-7507.

Once insurance has been billed and the claim processed, or if you do not have any insurance, any balance due will become your responsibility. We encourage you to contact our Business Office at the number above to review payment options, including applying for the ShoCare program. In the event we do not hear from you to set up payment options, or a bill becomes tardy, your account may be sent to a third-party collection agency. (The collection agency may charge you for attorney fees, out-of-pocket costs of collections and interest on any unpaid balance.)

By signing below as the Responsible Person, you are acknowledging that you have read and agree with your responsibility to pay any balance after applicable insurance and/or government agencies have processed your claim and any discounts have been applied to your account.

Also by signing below as the Responsible Person, this Authorization and Payment Agreement allows the patient to participate in outpatient treatment described above.

**RESPONSIBLE PERSON**

_____

Printed Name Relationship to Patient

_____ _____

Signature Date

This authorization will remain valid for a period of 12 (twelve) months from the date of signature unless revoked by me before that time. This authorization may be revoked by sending such revocation in writing to the HIM Director at 2755 Colonial Drive, Helena, MT 59601. Shodair will comply with the revocation unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization.

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# TELEMEDICINE INFORMED CONSENT

I understand the following:

- Telemedicine uses electronic communication systems that permit a health care provider at a distant location to provide treatment to me where I am located and/or consult with and advise my local health care provider in making and implementing decisions about the care provided to me.
- My medical history, physical examinations and earlier procedures may be discussed with the distant provider(s).
- My local health care provider may physically examine me while the distant provider watches through the telecommunications equipment. I can limit the examination at any time if it makes me uncomfortable.
- I understand and agree that me session may be interrupted or rescheduled if a more urgent patient care need arises.
- Authorized personnel may be in the room while the telecommunications equipment is in use.
- The telemedicine consultation will not be videotaped unless I have given my written consent to do so.
- If my condition worsens after leaving the hospital or clinic, I should return to my local health care provider or call my emergency medical service.

**The main benefit** of a video communications consultation is that the local health care provider and I can become quickly connected to medical services at a distant location while I stay near my home. Other benefits of this method of communications may include:

- I do not need to travel long distances to receive medical services
- Allowing a provider at a local site to make the best decision possible regarding my care.
- A distant provider or specialist, who may see me at another location for more treatment, will be familiar with my health history.
- My health care provider may be able to obtain information from a distant provider that may enable me to continue treatment at home.

**Risks** of telemedicine may include the following:

- Possible communications delay because of difficulty in telecommunications service or the need for an emergency consultation.
- Difficulty sending a clear picture to a distant provider.
- Possible loss of information because of equipment or communication line difficulties at either site.

**Other treatment choices:** I understand that instead of participating in telemedicine, I may choose:

- To have to travel to the city where the distant health care provider is located.
- Not to receive treatment; or
- Not to obtain or receive the additional or specialized health care advice that the distant health care provider might be able to provide.

**Financial Agreement** – I assume full responsibility for and agree to pay any charges incurred, regardless of insurance coverage. I agree that if this account is referred to collection, I will be responsible for all costs of collection.

**Release of Healthcare Information:** I authorize the hospital and anyone who provides services to release medical information to any third party or funding source which may be responsible for the costs of my care. I understand the purpose or need for the disclosure of this information is for the determination of benefits payable for the services provided to me by the hospital or provider.

**Questions** – I have had an opportunity to ask questions regarding the telemedicine consultation and they have been answered. I am satisfied with my understanding regarding the telemedicine consultation.

**Patient:** I have read and understand the above information and give my consent.

**Patient's Legal Guardian**: If the patient is unable to give consent because of mental infirmity, disability, or because the patient is a minor and the parent's consent is required for the telemedicine consultation, the patient's legal guardian should provide consent. As the below-named patient legal guardian, I verify that I have given my informed consent to this telemedicine consultation and that I act in the patient's behalf. I make all representations that the patient would under this form.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Patient / Legal Guardian Signature | Relationship to Patient | Date | Phone Number |

| _____ | _____ |
|---|---|
| PATIENT Name | PATIENT Date of Birth |

This authorization will remain valid for a period of 12 (twelve) months from the date of signature unless revoked by me before that time. This authorization may be revoked by sending such revocation in writing to the HIM Director at 2755 Colonial Drive, Helena, MT 59601. Shodair will comply with the revocation unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization.

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**Shodair Genetics Appointment Confirmation / Cancellation / No-Show Policy Signed Agreement**

Thank you for choosing Shodair Children's Hospital Department of Medical Genetics for your genetics consultation or neuropsychological evaluation. Our mission is to provide comprehensive diagnostic evaluation, clinical management, and genetic counseling for individuals in a timely manner. This requires a commitment from both patients and providers. We have the following expectations of our patients and families. By initialing the lines below, you are indicating that you agree with these policies. **These policies apply to both in person and telemedicine appointments.** Due to the nature of our specialty clinics, appointments are scheduled out several months. For this reason, we encourage you to keep your scheduled appointment to avoid prolonged wait times. If you need to cancel or reschedule your appointment, please be advised it may be several months until our next available appointment.

**Please read and initial the following terms**:

_____ 1. You will receive a reminder call **two weeks prior** to your appointment. You agree that you will respond within **one week** to confirm your appointment. If we do not hear from you within this timeframe, your appointment will be cancelled, and your slot will be filled. If this is the case, you will receive another call informing you of this cancellation.

_____ 2. If you know ahead of time that you cannot attend your appointment, you agree to contact our clinic a **minimum of two weeks prior** to your appointment. This will allow us to reassign the appointment to another patient. There is a waiting list to see our clinicians, and whenever possible we like to fill canceled spaces to shorten the waiting period for our patients. We understand that there are emergencies that may cause a cancellation less than two weeks prior to your appointment. If you are unable to keep your appointment, please contact us at 406-444-1160.

_____ 3. You agree to be on time for your appointment; we strongly encourage you to arrive 5-10 minutes early. If you arrive more than 15 minutes late, your appointment will be cancelled and marked as a No-Show. Our providers will not be able to see you that day. Your appointment will need to be rescheduled.

_____ 4. If you have confirmed your appointment but do not arrive at your scheduled date and time *without* letting our clinic know beforehand, your appointment will be marked as a No-Contact/No-Show. If this is the case, you agree to the following:
   a. It is **your responsibility** to contact our office to reschedule your appointment.
   b. If you call to reschedule, you will be placed at the bottom of our waitlist. You will be contacted to schedule once all patients ahead of you on the waitlist have been contacted. This process may take several weeks.
   c. Multiple instances of No-Show, late cancellation, or cancellation without a reasonable explanation may result in the patient being discharged from our clinic.

_____ 5. The patient themselves, including pediatric patients, must be present at their appointment. This applies for both telemedicine and in person appointments. If parents/legal guardians attend the appointment without the patient present, our providers will be unable to continue the appointment. Your appointment will be marked as a No-Show.

**I have read and understand** Shodair Genetics Appointment Confirmation / Cancellation / No-Show Policy. I understand it is my responsibility to plan appointments accordingly and notify the clinic if I need to make any changes to my appointment. I understand that failure to abide by these terms may result in prolonged wait times and a delay in my care, and/or discharge from the clinic.

**Patient Name:** _____ **DOB:** _____

_____ _____ _____

Signature of Patient/Legal Guardian | Relationship to Patient | Date

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*The following form is completely **optional.** Please only complete and sign if you wish to authorize additional individuals to schedule and/or confirm appointments on your behalf.*

## Shodair Children's Hospital Medical Genetics
## Patient Approved Phone Contacts Regarding Scheduling and Confirming Appointments

**Patient Name: _____ DOB: _____**

| Contact First & Last Name | Relationship to Patient | Phone # |
|---|---|---|
| | | |
| | | |
| | | |

The HIPAA Privacy Rule permits health care providers to communicate limited information regarding a patient's appointment with appropriate patient approved contacts. In the event the patient/legal guardian cannot be reached, Shodair Medical Genetics staff will be allowed to communicate appointment reminders and/or scheduling information with the individual(s) identified above as authorized by this consent.

***Note that this is not a form to allow release or disclosure of protected healthcare information.***

_____ _____
Signature of Patient/Legal Guardian Date

_____
Relationship to Patient