TRINITY PEDIATRICS, P.C.
DESIGNATION OF DISCLOSURE FORM

❖ I wish to be contacted in the following manner (check all that apply)

VERBAL COMMUNICATION	WRITTEN COMMUNICATION
Home Telephone# __________________________	___Ok to mail to my home address
___Ok to leave a message with detailed information	_______________________________
___Ok to leave a message with call back number ONLY	_______________________________
	___Ok to mail to my work/office
Work Telephone# __________________________	_______________________________
___Ok to leave message with detailed information	_______________________________
___Ok to leave message with call back number ONLY	Fax# __________________________
	Email Address __________________________

❖ Designation of disclosure

I agree that TRINITY PEDIATRICS, P.C. may disclose certain information regarding my medical information to a family member, close personal friend, or other caregiver because such person is involved with my healthcare or payment relating to my healthcare. In that case, TRINITY PEDIATICS, P.C. will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of TRINITY PEDIATRICS, P.C. to make the type of disclosure listed above.

I understand that I am not required to list anyone and that I may change this list at any time in writing.

NAME	RELATIONSHIP	TELEPHONE#

____ ____________________
Patient's name Date of birth

____ ______________________
Signature of Patient/Parent/Guardian Date