PEDIATRICS OF SUGAR LAND
16651 SOUTHWEST FWY #180
SUGAR LAND , TX 77479

PERMISSION REGARDING COMMUNICATIONS / HIPAA FORM

I give permission to Little Buddies Pediatrics PA. DBA Pediatrics of Sugar Land staff to communicate information regarding medical care and appointments relating to:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

The communication can be delivered by the following (Please ✓the box if permissible):

Appointment Message		**Medical Information**		
Home Phone	☐	Home Phone	☐	**Home #:** _____
Mobile Phone	☐	Mobile Phone	☐	**Mobile #:** _____
Send via E-Mail	☐	Send via E-Mail	☐	
Send via Patient Portal	☐	Send via Patient Portal	☐	**Email #:** _____

I give permission to Pediatrics of Sugar Land staff to discuss with the following listed individual(s), information reasonably deemed to be directly related to such individual's involvement on the above referenced patients' health care: (examples: Grandparents / Relatives / Babysitters / Step-Parents, etc.)

Name: _____ Name: _____
Relationship to patient: _____ Relationship to patient: _____
Phone #: _____ Phone #: _____

Name: _____ Name: _____
Relationship to patient: _____ Relationship to patient: _____
Phone #: _____ Phone #: _____

I understand that I may change the above information at any time by sending my written request to my physician. Any change requested does not affect any communication previously made in reasonable reliance on this form. I have had the opportunity to receive and read the Pediatrics of Sugar Land Notice of Privacy Practices.

_____ _____ _____
Parent / Legal Guardian (**Print Name**) Parent / Legal Guardian (**Signature**) Date