Kansas City Pediatrics
Communication Authorization

Patient Name_____ **Date of Birth**_____

I, the above patient, or legal guardian for,give permission for Kansas City Pediatrics to communicate with me at the numbers listed below.

CHECK ALL NUMBERS THAT APPLY

_____My home telephone number is:_____
_____OK to leave a message with detailed medical information.
_____OK to leave a message with callback number only.

_____My work telephone number is:_____
_____OK to leave a message with detailed medical information.
_____OK to leave w message with callback number only.

_____My cellphone number is:_____
_____OK to leave a message with detailed medical information.
_____OK to leave a message with callback number only.

I am also giving you permission to discuss the healthcare needs of the above patient with the following individual(s), ie. Any other family members, fiancé, babysitter's, etc…

PLEASE NOTE: We can only discuss the information with the person(s) you name below and no one else. It is up to you to update this sheet accordingly.

Name of individual	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient or Legal Guardian Signature Date