AUSTIN CHILDREN'S CLINIC, PA

CONSENT FORM

Children's Names: **DOB**

_____ _____

_____ _____

_____ _____

_____ _____

Please initial each appropriate statement and then sign below to give consent.

Appointment Reminders:

_____ It is OK to leave a message on voice mail, recording device or with any **adult** persons answering my **Home** phone.

_____ It is OK to leave a message on voice mail or a recording device at my/spouse's **Work** phone.

_____ It is OK to mail reminder cards to my home address.

Lab Results:

Our office will not leave messages for positive results or any results on tests of a sensitive nature. Additionally, we will not leave lab results at a work phone number.

_____ It is OK to leave a message **for negative lab results** on voice mail, recording device or with any **adult** persons answering my **Home** phone.

_____ It is NOT OK to leave a message for any lab results. If I am not available at home please try the following number: Phone # _____ Contact person _____.

I understand any changes to or revocation of this consent must be made in writing.

_____ _____

Signature Parent/Legal Guardian Date