Voice Message Authorization

Patient Name(s): ______________________________________ Date: __________

☐ I hereby **AUTHORIZE** Young Kids Pediatrics to leave notifications by voice message regarding my child's care and/or test results at the following phone numbers:

- **1st CHOICE**: ( ) Parents ( ) Mother ( ) Father ( ) Legal Guardian ( ) Patient

  ( ) Home ( ) Work ( ) Cell

  Phone Number: ___________________________

- **2nd CHOICE**: ( ) Parents ( ) Mother ( ) Father ( ) Legal Guardian ( ) Patient

  ( ) Home ( ) Work ( ) Cell

  Phone Number: ___________________________

☐ I **DO NOT AUTHORIZE** Young Kids Pediatrics to leave voice messages regarding my child's care and/or test results at any of my numbers.

I have read and understand this agreement and have made the necessary documentation above. I understand that I may revoke or make changes where necessary to this agreement at any time.

Signature: ___________________________ Relationship to Patient: _______________

(Parent/Legal Guardian/Patient over 18)