Allegro PEDIATRICS

NEXPLANON

Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ Date of Birth: _____

(Please check all that apply)

____ My cell phone number (____)_____

____ OK to leave a message with test results if normal and I don't answer

____ OK to talk to the following people about Nexplanon (insertion, follow-up, removal appointments)

____ Parent 1:

Name: _____ Relationship: _____ Phone #: (____)_____

____ Parent 2:

Name: _____ Relationship: _____ Phone #: (____)_____

____ Other Caregiver:

Name: _____ Relationship: _____ Phone #: (____)_____

Please keep the following confidential:

____ Sexual history

____ Sexually transmitted infection test results

With my signature below I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____ _____

Signature of Patient Date