



Anshu Dalela, MD

### Preferred Method of Communication

My preferred method of communication regarding patient's **medical information** is:

- Home Phone       Work Phone       Cell Phone

Please check the appropriate box:

- Leave a message with detailed information       Leave a message with a call back number

I would like to receive any **office updates** via text message:

- Cell Phone Number(s) \_\_\_\_\_

- I would **NOT** like to receive any office updates via text message

### Non Parental Consent to Medical Treatment

Occasionally, someone other than the parent/legal guardian may need to bring your child for medical care. Please list those authorized to provide consent when you are unavailable:

- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
- Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize the individuals listed above to consent to any medical care/treatment for this child by a White Cloud Pediatrics provider. This authorization remains in effect until revoked.

**(If no one is listed, please sign below to confirm you have read this section)**

Guarantor / Responsible Party's Name: \_\_\_\_\_

Guarantor / Responsible Party's Signature: \_\_\_\_\_

Date: \_\_\_\_\_