ATLANTA MIDTOWN GYNECOLOGY INC

PATIENT CONFIDENTIALITY

Patient Name: _____

Date of Birth: _____

Patient confidentiality is a top priority at Atlanta Midtown Gynecology. Therefore, it is important that you provide us information to ensure then is no violation of your privacy when we attempt to communicate with you.

Please list any family members who may obtain/call/discuss your medical information:

1. _____
2. _____
3. _____

In the event that I, _____, am unable to be contacted by Atlanta Midtown Gynecology staff regarding lab results, test results, scheduling, surgery, procedures, messages or other sensitive health information……

_____ I give permission for this information to be discussed with the above listed family members

_____ I DO NOT give permission for this information to be discussed with anyone other than myself.

Please list all ways in which Atlanta Midtown Gynecology staff may attempt to contact and communicate with you. (check all that apply)

_____ Voicemail (home or cell)
_____ Answering machine at home
_____ Email
_____ Text message
_____ Message at work to return call
_____ Mail/Postcards/Recall Cards
_____ Fax
_____ Other: _____

PATIENT SIGNATURE DATE