Patient Name: _____ DOB:_____

PATIENT COMMUNICATION PREFERENCES

Our office will need to contact you to schedule and/or reschedule appointments, relay lab and/or test results and other such administrative issues. To ensure that your privacy is fully maintained, please select the method(s) by which our office may contact you.

NAME: _____ DOB: _____

	May we leave a Message?	May we leave results?
Home Phone: _____	YES / NO	YES / NO
Work Phone: _____	YES / NO	YES / NO
Cell Phone: _____	YES / NO	YES / NO
Fax: _____	YES / NO	YES / NO
Email: _____	YES / NO	YES / NO

I give authorization for Georgia Nephrology to discuss my medical records with: (example: spouse, child, friend, caregiver. Please do not list your other physicians as we do not need permission to discuss your care with them.

You may choose to leave this area blank if you do not wish for us to discuss your information with anyone but you).

Name: _____ Relationship: _____

Phone #(s): _____

Name: _____ Relationship: _____

Phone #(s): _____

Name: _____ Relationship: _____

Phone #(s): _____

SIGNATURE: _____ DATE: _____