North Atlanta Pediatric associates

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Patient Agreement For Communications

We are committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information, or other private health information to anyone other than the patient or guardian nor leave messages about test results on voicemail or answering machine without your permission.

You may contact me at the phone number(s) listed below with test results and other medical information. I have checked the number I prefer you call. If no numbers are listed, we will only call the primary number listed in our records.

☐ **Home** _____ ☐ **Work** _____

☐ **Cell** _____ ☐ **Other** _____

_____ _____
Patient Name (printed) Date of Birth Parent or Patient Signature (if 18 or older) Date

_____ _____
Patient Name (printed) Date of Birth Parent or Patient Signature (if 18 or older) Date

_____ _____
Patient Name (printed) Date of Birth Parent or Patient Signature (if 18 or older) Date

_____ _____
Patient Name (printed) Date of Birth Parent or Patient Signature (if 18 or older) Date

I authorize North Atlanta Pediatric Associates to communicate with the following person(s) on my behalf. I authorize the individual(s) listed below to seek and obtain treatment for my child / children. This authorization will continue until revoked in writing by me and supersedes all previous notifications.

Name	**Relationship**	**Phone**	**Information to Provide (circle)**
			Medical Financial
			Medical Financial
			Medical Financial
			Medical Financial

_____

Parent or Patient Signature (if 18 or older) **Date**