North Atlanta Women's Care

Alternative Contact Authorization

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to contact me or leave messages for me at my place of work.

Initial _____ **Date** _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to contact me at my E-mail address.

E-Mail Address if authorized: _____

Initial _____ **Date** _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to contact me by text.

Cell Phone Number if authorized: _____

Initial _____ **Date** _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to discuss my appointments. Medical evaluation, treatment and results to relatives or other persons as indicated:

Authorized person(s)/relationship _____

Initial _____ **Date** _____/_____/_____

I hereby authorize North Atlanta Women's Care PC to leave messages on my home answering machine/voicemail regarding appointments and to inform me that lab work or ultrasound results are available. I realize I must call the office to obtain the results.

Initial _____ **Date** _____/_____/_____

I □ **DO** □ **DO NOT** authorize North Atlanta Women's Care PC to leave messages on my home answering machine/voicemail to inform me if my lab work or ultrasound results are **normal**. I realize that I must call the office if I have any concerns or questions regarding the results.

Initial _____ **Date** _____/_____/_____

I acknowledge that I have received a copy of the "NOTICE OF PRIVACY PRACTICES" and "PATIENT RIGHTS & RESPONSIBILITIES" for my records.

Initial _____ **Date** _____/_____/_____

I have been provided with a copy of the Clinic's Grievance Policy.

Initial _____ **Date** _____/_____/_____