COMMUNICATION AUTHORIZATION

_____
CHART #

PATIENT NAME:_____
LAST FIRST MIDDLE DATE OF BIRTH

When it comes to your medical treatment, we strive to communicate with you in a timely and professional manner. You may leave messages with, discuss my treatment, appointment or other scheduling that may occur or give other information as necessary with the following family, friends or personal representatives. I understand that Augusta Renal Physicians, PC will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this consent does not apply to medical providers.

PLEASE LIST BELOW THOSE INDIVIDUALS WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS ASPECTS RELATED TO YOUR CARE.

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

You are also provided the right to request confidential communications of your protected health information be made by alternative means, such as sending correspondence to your office instead of your home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER: (CHECK ALL THAT APPLY)

Home Telephone

☐Okay to leave message with detailed information

☐Leave message with call-back number only

Work Telephone

☐Okay to leave message with detailed information

☐Leave message with call-back number only

Written Communication

☐Okay to mail to my home address

☐Okay to mail to my work/office

☐Okay to fax to this fax number:_____

_____ _____
PATIENT SIGNATURE **DATE**