



PEACHTREE GYNECOLOGY

1800 Peachtree Road N.W.
Suite 650
Atlanta, GA 30309

Patient Contact Information
Please **PRINT** Clearly

Patient Name _____ Date of Birth _____

To be HIPPA compliant we need **you** to tell us how to contact you with your health information. You need to be very specific regarding how you prefer to be contacted and where we can leave clinical messages and tests or lab results.

How do you prefer to be contacted? Email _____

Please provide the contact information. Cell Phone _____

Work Phone _____

Home Phone _____

Other _____

Are we able to leave personal messages? Yes _____ No _____ If Yes, please sign consent.
If no, we will leave only a general message to call us back. It is your responsibility at that point to call us back.

I hereby give Peachtree Gynecology permission to leave clinical/medical messages, which may include personal and sensitive information on the media source(s) that I have indicated above.

Signature _____ Date _____

If you are unavailable, is there anyone that you give us permission to leave such messages with?
Yes _____ No _____ If yes, provide their name, relationship to you and contact information.

Name _____ Relationship _____ Ph _____