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PATIENT COMMUNICATION PREFERENCE

I authorize the following persons to have full access to my health information:

Name of Contact (Please PRINT)	**Relationship to Patient**	**Date**
Name of Contact (Please PRINT)	**Relationship to Patient**	**Date**
Name of Contact (Please PRINT)	**Relationship to Patient**	**Date**

I, ___________________________ give my permission for you to leave any medical or laboratory information regarding my health information at the following:

Home Phone: ______________________________

Mobile Phone: ______________________________

Work Phone: ______________________________

Email: ______________________________

Mailing Address: ______________________________

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I, the undersigned, give my permission for Atlanta Heart Specialists, LLC, to disclose my health information as described herein. **Any changes to my communication preferences must be submitted in writing.** Atlanta Heart Specialists is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Date	Signature of Patient or Legal Representative	Relationship to Patient