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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: _____

_____

_____

_____

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