MEDICAL ASSOCIATES OF THE SHOALS, P.C.

PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of Medical Associates of the Shoals, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons:

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **I do not want anyone to have access to my protected health information unless I provide explicit authorization.**

PATIENT SIGNATURE: _____DATE: _____

If unable to reach me:

☐ You may leave a detailed message.

☐ Please leave a message asking me to return your call.

☐ Do **NOT** leave a message.

PATIENT SIGNATURE: _____DATE: _____

IF ANY INFORMATION ON THIS FORM CHANGES, IT IS THE PATIENT'S RESPONSIBILITY TO NOTIFY MEDICAL ASSOCIATES IMMEDIATELY.