ALPHA MEDICAL CENTRE

3000 OLD ALABAMA ROAD, SUITE 128A, GA 30022 PH 770-821-1940 FAX 770-821-1950

1. Please list all names and relationships of individuals with whom you authorize us to share your health information and billing information with:

_____
_____
_____
_____

2. I wish to be contacted in the following manner (Re: Test results, billing issues, appointments, or any other reason):

(Check all that apply)

___Home Telephone_____

___It is okay to leave message with detailed information.

___Leave message to call back only.

___Work Telephone_____

___It is okay to leave message with detailed information.

___ Leave message to call back only.

___Written Communication

___It is okay to mail to my home address.

___It is okay to mail to my work/office address.

___It is okay to fax to my private fax to my private number: _____

3. I acknowledge the receipt of the HIPAA privacy policy for Alpha Medical Centre and that a copy of a HIPAA Privacy Policy is available to me upon request at any time.

Please Print Name: _____ Relation _____

Please Sign: _____ Date _____