Georgia Infectious Diseases, PC
5673 Peachtree Dunwoody Rd NE, Suite 600 · Atlanta, Georgia 30342
Phone: (404) 256-4111 · Fax: (404) 256-0040

CONSENT TO COMMUNICATE HEALTH INFORMATION

As a patient, you may designate a partner, family member, friend, or other persons with who Georgia Infectious Diseases, P.C. can communicate about your health care status. This form is not required in all circumstances for your doctor or others at Georgia Infectious Diseases, P.C. to be able to communicate with your family about your health care. However, by designating on this form certain individuals who you want to be informed about your care, you can ensure that your provider can communicate without delay with the person(s) you designate below.

I, _____, hereby consent to have my health information and care discussed with the following individual(s):

_____	_____	_____
Name	*Relationship*	*Phone Number*
_____	_____	_____
Name	*Relationship*	*Phone Number*
_____	_____	_____
Name	*Relationship*	*Phone Number*

I understand that this consent can be revoked by submitting a written request to Georgia Infectious Diseases, P.C. I understand that I have the right to revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. This consent shall remain in effect until such time as I revoke it in writing.

By signing below I indicate that I have read and understood the policy described above.

_____	_____
Signature of Patient or Legal Surrogate	**Date** **Time**
_____	_____
Printed Name of Patient or Legal Surrogate	**Relationship (If Legal Surrogate)**