G&K MEDICAL ASSOCIATES, P.C.

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Patient Communication Form

Patient Name:_____ Date of Birth:_____

We must call on occasions to discuss confidential protected health information. Below is a list of ways for us to communicate this information to you. Please check how you would prefer for us to get this information to you.

☐ Okay to call my home and leave a message

☐ Call my home phone but DO NOT leave a message

☐ Do NOT call home phone, call only this number:
(____) _____ - _____
Can we leave a message: ☐ Yes ☐ No

☐ Do NOT speak to family members or anyone not listed below.

I give permission to individuals listed below to receive protected health information:

1._____

2._____

3._____

I have received and reviewed a copy of G&K Medical Associates Notice of Privacy Practices and understand how my health information may be used and disclosed.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date