Surgical Associates
OF NORTH ALABAMA, P.C.

Patient Contact Information Sheet

Patient Name: _____

Social Security Number: _____

Any physician staff, employee or representative of Surgical Associates of North Alabama has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, appointments or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment. This also includes text messages sent to Surgical Associates of North Alabama physicians, orders, prescriptions, work forms and any other items that need to be picked up by someone other than myself. You do not need to list physicians.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can revoke this form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

I have received a privacy statement/information from this office. Yes No

In addition, how may we communicate with you? Please circle all that you approve.

Home phone Work Phone Cell phone Mail

May we leave you a message: Yes No

Patient Signature: _____ Date:_____