Piedmont HEALTHCARE

Privacy Questionnaire

Patient Full Name:_____ DOB:_____

Current Address:_____

Please review and answer the following questions in regards to your protected health information.

The contact information and phone numbers you provide will be used as agreed to below. Please note that the information will be in effect for both Piedmont Physicians and Piedmont Heart Institute locations as applicable.

1. ❑ I give permission to leave a detailed message regarding my healthcare on the phone number provided below:

   Phone number:_____

   Phone number:_____

   ❑ No please only leave a callback name and number when you attempt to reach me.

2. I give permission to discuss my medical information with the following individuals:

   - Name:_____ Relationship:_____
   - Name:_____ Relationship:_____
   - Name:_____ Relationship:_____
   - Name:_____ Relationship:_____

Authorization Signatures:

Your signature below further indicates your understanding that this authorization will be valid for a period of one year from today's date and will expire at that time unless another form is completed. You may revoke or request changes to this authorization at any time by completing a new Privacy Questionnaire.

Patient/Legal Representative Signature	Patient/Legal Representative Name (**PRINT**)	Date	Time

Relationship to Patient	Reason Patient is unable to sign