809 Cleveland Ave S.W.
Atlanta, GA 30315
404-767-2536 / Voice
www.cwhallc.com

Consent for Communications

I understand that as part of my heath care; Comprehensive Women's Healthcare Atlanta LLC will need to contact me for a variety of reasons including but not limited to: A) appointment reminders, B) clinical instructions, and C) lab results.

My signature below authorizes Comprehensive Women's Healthcare Atlanta LLC to contact me as follows:

	Number	Voicemail Authorization
Home Phone	_____	__ YES __ NO
Work Phone	_____	__ YES __ NO
Cell Phone	_____	__ YES __ NO
Fax	_____	__ YES __ NO

I understand that Comprehensive Women's Healthcare Atlanta LLC does not utilize a secure server for e-mail and as such cannot transmit clinical information via e-mail. I authorize Comprehensive Women's Healthcare Atlanta LLC to transmit administrative information including but not limited to: A) appointment information and B) billing/insurance information to me via e-mail as listed below.

E-mail Address(es)	Authorized
	__ YES __ NO
	__ YES __ NO

I would prefer that Comprehensive Women's Healthcare Atlanta LLC contact me in the following manner:

1.
2.
3.

I understand that Comprehensive Women's Healthcare Atlanta LLC will transmit the minimum amount of information possible when contacting me via these methods. I further understand that I may modify or revoke my authorizations at any time but that such modifications or revocations must be in writing and will not apply to communications prior to the date the authorization was modified or revoked.

Patient Name:_____ **Date Signed:**_____

Signature of Patient or Guardian: _____

I authorize Comprehensive Women's Healthcare Atlanta LLC to discuss matters related to my medical care with the following individuals:

_____ _____
Name (Please Print Clearly) Relationship to patient

_____ _____
Name (Please Print Clearly) Relationship to patient

_____ _____
Name (Please Print Clearly) Relationship to patient