Greensboro Medical Associates, PA
1511 Westover Terrace, Suite 201
Greensboro, NC 27408
(336) 373-0611

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Patient Name (Full Name)

I Authorize Greensboro Medical Associates to:

- ☐ Leave messages on my answering machine or voice mail
- ☐ Report test results to ____
  ____
  (Please list full name and phone number)
- ☐ Discuss charges or payments on my account with me or __________________________
  (Please list full name)
- ☐ Mail to my "Address of Record" any reports or appointment changes
  My Address of Record: _________________________ _________________ ___ _____
  (Street) (City) (State) (Zip)
  Phone Number: _________________________ Other Number: ___________________
- ☐ Other (List any specific directions at the bottom of this form)

_______________________________________ ______________________________
Patient or Representative Name (Print) Drivers License Number and State

_______________________________________ ________________
Patient or Representative Signature Date

- ☐ Patient Refused to Sign
- ☐ Patient was unable to sign because ____

Emergency Contact

____ _______________________
Name of Emergency Contact (Please Print) Relationship

(_______)_________________
Telephone Number of Contact

In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

List any specific directions regarding the disclosure of your health information:

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