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Rome, GA 30165

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706-252-8118 FAX
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TRUPOINT Physicians

PATIENT COMMUNICATION RELEASE FORM

There may be times we will need to contact you. If we are unable to reach you directly, may we leave a message on your voice mail? ◯ Yes ◯ No

AND/OR

May we leave a message with the individual who answers the call? ◯ Yes ◯ No

If we leave a message, we will not leave medical information.

Is there someone, other than yourself, we may discuss your medical treatment and payment:
◯ Yes ◯ No

◯ I do not wish TruPoint Physicians' providers or staff to speak to anyone other than myself.

You may speak to the following individuals about my medical care and payment:

Name: _____ Phone: _____

Relationship to Patient: _____

Name: _____ Phone: _____

Relationship to Patient: _____

I acknowledge that I have received or been offered a copy of the TruPoint Physicians Notice of Privacy Practices.

I have read and understand the above information. All of my questions have been answered to my satisfaction.

_____ _____

Signature of Patient/ Patient Representative Date