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Atlanta, GA 30309
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PATIENT PRIVACY QUESTIONNAIRE

Patient Name:_____

1. May we give confidential information to individuals you designate regarding appointments, lab results or other healthcare information?

   Yes No

   If yes, please list individual(s) below:

   Name:_____

   Relationship:_____

   Phone Number:_____

   Name:_____

   Relationship:_____

   Phone Number:_____

   Name:_____

   Relationship:_____

   Phone Number:_____

_____ _____

Signature of patient Date