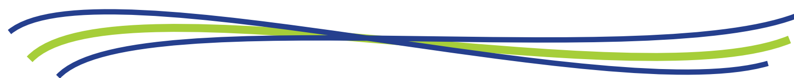

David Kim, M.D. 770-435-3214

Karen Artress, M.D

Radhika Rao, D.O. 770-801-6686

Michael E. Allen, P.A

Patient Name: (Please print legibly)____

Date of Birth :___________________________________

PATIENT CONFIDENTIALITY

Patient confidentiality is top priority at Cobb Medical Associates. Therefore, it is important the you provide us with the following information to ensure there is no violation of your privacy.

In the event that I,___________________________________ am unable to be reached, Cobb Medical Associates may leave test results or other pertinent information with the following.

[] Spouse (Name)______________________________

[] Children (Name and Phone Number)_____________________________

[] May leave test results on home answering machine

[] I may be reached at work (Number)____________________________

[] May leave message at work on voicemail

[] May leave message on cellphone (Number)________________________

[] Other (Describe) __________________________________

(Initials) _________ In the event I am unable to be reached, Cobb Medical Associates may not leave test results or any other information with **anyone** but myself

I understand that is the status of any of the above information changes, it will be my responsibility to inform the staff of Cobb Medical Associates.

Patient's Signature_______________________________________ Date _________

3903 South Cobb Drive Suite200 Smyrna, Georgia 30080-6300 www.cobbmedicalassociates.com