



Gastro Consultants of Atlanta, P.C.

Specialists in Digestive and Liver Diseases

Alan M. Fixelle, M.D., F.A.C.G.

Patient Agreement for Communications

I _____ Date of Birth: _____,
understand that as part of my health care Gastro Consultants of Atlanta, P.C. will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Gastro Consultants of Atlanta, P.C. to contact me in the following ways:

_____ Home Phone (voice mail) Number: _____

_____ Office Phone (voice mail) Number: _____

_____ Cell Phone (voice mail) Number: _____

_____ Fax Number: _____

_____ Email Email address: _____

I authorize Gastro Consultants of Atlanta, P.C. to speak with the following person/s and release information on my behalf:

I understand that Gastro Consultants of Atlanta, P.C. will convey the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already completed.

Date

Print Name

Signature of Patient or Authorized Party

Relationship to Patient