

# GEORGIA KIDNEY ASSOCIATES, INC.

## PATIENT CONFIDENTIALITY FORM

**TO ENSURE THAT THERE IS NO VIOLATION OF YOUR PRIVACY, PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION:**

In the event that I, \_\_\_\_\_, cannot be reached, Georgia Kidney Associates, Inc. may leave any test result, lab result, appointment information or other confidential medical information with the following:

*Please circle all that apply:*

**Spouse** Name: \_\_\_\_\_ Number: \_\_\_\_\_

**Children** Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

**Home Voice Mail:** Number: \_\_\_\_\_

**Work Voice Mail:** Number: \_\_\_\_\_

**Cell Voice Mail:** Number: \_\_\_\_\_

**Other** Name: \_\_\_\_\_ Number: \_\_\_\_\_

Name: \_\_\_\_\_ Number: \_\_\_\_\_

If there is anyone you **DO NOT** wish us to discuss this information with, please specify below.

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\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE