Carroll Health Group

Consent & Disclosure

Patient Consent For Alternate Contact

I hereby give my consent for Carroll Health Group, LLC (CHG) to disclose protected health information ("PHI" including, for instance, appointment reminders or test results) about me or my dependent to the following trusted persons in conformance with CHG's Notice of Privacy Practices ("NPP"). CHG's NPP more completely describes *why* and *how* such information may be disclosed.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CHG and its affiliates reserve the right to revise the Notice of Privacy Practices at any time.

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

Name: ______________________________

Relation to Patient: ___________________

Phone Number: ______________________

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Signature of Patient or Legal Guardian

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Date

____

Print Patient's Name

____

Print Name of Legal Guardian (if applicable)

For office use only:

____

CHG Associate

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Date Received