

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: _____

Name: _____

Relation to Patient: _____

Relation to Patient: _____

Phone Number: _____

Phone Number: _____

Name: _____

Name: _____

Relation to Patient: _____

Relation to Patient: _____

Phone Number: _____

Phone Number: _____

Signature of Patient or Legal Guardian

Date

Print Patient’s Name

**Print Name of Legal Guardian
(if applicable)**

For office use only:

CHG Associate

Date Received