AUGUSTA ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS, PC
Patient Acknowledgement & Record of Disclosures

Date:

I, _____ acknowledge that I have the right to review or received the written Notice of Privacy Practices and Record Disclosure.

☐ The patient's condition prohibits the individual from signing an acknowledegment at this time. It will be obtained as reasonably practicable after the patient's condition improves.

I wish to be contacted in the following manner (check all that apply):

☐ Home/Cell Telephone
- ☐ Leave message with detailed information
- ☐ Leave message with call back number

☐ Work Telephone
- ☐ Leave message with detailed information
- ☐ Leave message with call back number only

☐ Written Communication
- ☐ Can mail to Home address
- ☐ Can mail to Work address
- ☐ Can fax to this number: _____

I consent to have my personal health information disclosed to my:

☐ Spouse: _____

☐ Parent: _____

☐ Parent: _____

☐ Other: _____

It is against the policy of Augusta Orthopedic & Sports Medicine Specialists, PC to record (visual or audio) any of our staff without permission from the treating physician.

_____ **Date of Birth** _____

Patient's Name or Representative