William H. Megdal, M.D.
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(706) 425-2400 Phone
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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the **N**otice of **P**rivacy **P**ractices of Athens Spine Center on the date indicated below. I understand that if any changes are made to this **N**otice of **P**rivacy **P**ractices, a revised copy of the **N**otice will be posted in the offices of Athens Spine Center. I also understand that if I wish to receive additional copies of this **N**otice of **P**rivacy **P**ractices in the future or if I have any questions with regard to this **N**otice of **P**rivacy **P**ractices, I may contact Athens Spine Center at 706-425-2400.

_______________________________________ _______________________________
SIGNATURE OF PATIENT *DATE*

_______________________________________ _______________________________
PRINTED NAME OF PATIENT *WITNESS*

CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Athens Spine Center PC, doctors and medical staff to disclose my personal medical information to the following individuals:

NAME: ___________________________________ *RELATIONSHIP:* _________________________

NAME: ___________________________________ *RELATIONSHIP:* _________________________

NAME: ___________________________________ *RELATIONSHIP:* _________________________

CONDITIONS FOR DISCLOSURE:

The practice may disclose my personal health information to the individual(s) above ***only*** in my presence.

The practice may disclose my medical information to the individuals above in discussions in my presence ***and*** when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Other Conditions of Disclosure:____
____

I understand that this consent is in effect until revoked by me by written notice to the practice.

_______________________________________ _______________________________________
PATIENT SIGNATURE *WITNESS*

____
PRINTED NAME OF WITNESS

_______________________________________ _______________________________________
DATE *TITLE/POSITION* *DATE*