



**William H. Megdal, M.D.**  
**Benjamin E. McCurdy, M.D.**  
 855 King Avenue  
 Athens, Georgia 30606  
 (706) 425-2400 Phone  
 (706) 425-2410 Fax

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

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

<i>SIGNATURE OF PATIENT</i>	<i>DATE</i>
<i>PRINTED NAME OF PATIENT</i>	<i>WITNESS</i>

**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.

<i>PATIENT SIGNATURE</i>	<i>WITNESS</i>
	<i>PRINTED NAME OF WITNESS</i>
<i>DATE</i>	<i>TITLE/POSITION</i> <span style="float: right;"><i>DATE</i></span>