

GASTON FOOT & ANKLE ASSOCIATES, PA
251 WILMOT DRIVE
GASTONIA, NC 28054
704-861-0425

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:
Patient Name:
Address:

I understand and am aware of the Notice of Privacy Practices. If I so choose, a copy of the Notice is available to me by request.

PARENT OR AUTHORIZED REPRESENTATIVE (if applicable)

SIGNATURE: _____

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 Gaston Foot & Ankle Associates, PA and Doctor _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Conditions for Disclosure (Check the item(s) that apply):

- 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 individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.
- Other Conditions of Disclosure: _____

I understand that this consent may be revoked by me at any time by written notice to the practice.

Patient Signature: _____

Date of Signature: _____

Witnessed by: _____ Title/Position: _____

Printed Name of Witness: _____

Date: _____