- CONSENT TO LEAVE MEDICAL INFO WITH SOMEONE OTHER THAN THE PATIENT

I am authorizing the personnel at Wake Orthopaedics, LLC to leave information related to my medical care with others if I am not available. Check all that apply:

_____ I authorize that information can be left with my wife/husband/significant other.
Name of person:____.

_____ I authorize that information can be left on my answering machine (phone #): __________.

_____ I authorize that information can be left on my voice mail (phone #): _________________.

_____ Other: I authorize that information can be left:

____.
I understand that this authorization will be valid until I give written notification otherwise.

- RECEIPT OF NOTICE OF PRIVACY PRACTICES: WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________________, have received a copy of Wake Orthopaedics, LLC Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information (PHI).

________________________________ ______________________
Signature of Patient **Date**

Relationship to Patient (if signed by a personal representative of patient:

________________________________ ______________________
Patient Personal Representative Date

________________________________ ______________________
Witness Date