

By signing below, I hereby acknowledge receipt of the *Privacy Notice*.

Signature of Patient or Legal Guardian

Date

I give permission to the Carrollton Orthopaedic Clinic, P.C. and/or West Georgia Rheumatology to disclose any information regarding my treatment to the following people in the event that they may need information about me over the telephone:

Name(s)

Parent(s)

Child(ren)

Friend(s)

Other

To be completed by Carrollton Orthopaedic Clinic, P.C.:

After a good-faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

Signature of Carrollton Orthopaedic Clinic Representative

Date