ATHENS ORTHOPEDIC CLINIC, P.A.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1966 (HIPAA)

I have had the opportunity to review and/or request a copy of the Notice of Privacy Practices of ATHENS ORTHOPEDIC CLINIC, P.A. 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 at the office.

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:

Becky Hockaday, COO, Athens Orthopedic Clinic, P.A., 1765 Old West Broad St., Athens, GA 30606

I also hereby authorize the following individuals to have access to my medical records:

Name: _____

Relationship: _____

Phone: _____

eRx CONSENT

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your provider see important information like drug interactions and your prescription history.

I agree that Athens Orthopedic Clinic may request and use my prescription medication history from other healthcare providers or pharmacy benefit payors for treatment purposes.

By signing below, I acknowledge that I have read and understand the above.

_____

Signature of Patient or Guarantor

PRINT NAME:_____

DATE:_____