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The Hand & Upper Extremity
 CENTER OF GEORGIA, P.C.
 SURGERY OF THE HAND, ELBOW AND SHOULDER

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(404) 255-0226 • www.HandCenterGA.com

Patient Agreement for Communications

I _____, understand that as part of my health care, *The Hand & Upper Extremity Center of Georgia, P.C.* will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow -up after a procedure, etc. I hereby authorize *The Hand & Upper Extremity Center of Georgia, P.C.* to contact me in the following ways:

(Check all that apply and provide numbers/e-mail addresses)

____ Home Phone: _____ Leave voice mail? ____ yes ____ no

____ Mobile Phone: _____ Leave voice mail? ____ yes ____ no

____ Office Phone: _____ Leave voice mail? ____ yes ____ no

____ E-mail Address: _____

____ Fax: _____

My condition and medical information can be discussed with the following person(s) on my behalf:

1. _____
 Name Relationship

2. _____
 Name Relationship

3. _____
 Name Relationship

I understand that *The Hand & Upper Extremity Center of Georgia, P.C.* will use the minimum necessary information needed when communicating with me indirectly. I understand that I have the right to revoke or amend this agreement at any time. Any revocation or change will not apply to any communications already completed. I understand that *The Hand & Upper Extremity Center of Georgia, P.C.* will not share this information with any third party vendors or parties at any time.

 Patient's Signature

 Date