Bronier L. Costas, M.D.
Gary M. Lourie, M.D.
Allan E. Peljovich, M.D., M.P.H.
Jeffrey A. Klugman, M.D.
Joshua A. Ratner, M.D.
Bryce T. Gillespie, MD.

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

Northside Hospital Doctors Centre
980 Johnson Ferry Road NE, Suite 1020
Atlanta, Georgia 30342

Northside/Alpharetta Medical Campus
3400A Old Milton Parkway, Suite 350
Alpharetta, Georgia 30005

Hand & Upper Extremity Surgery Center
993D Johnson Ferry Road NE, Suite 200
Atlanta, Georgia 30342

(404) 255-0226 • www.HandCenterGA.com

PATIENT'S 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 The Hand & Upper Extremity Center of Georgia, P.C. to contact me in the following ways:

(Check all that apply and provide numbers/email addresses)

Home Phone: _____ Leave voice mail? ☐ Yes / No ☐
Mobile Phone: _____ Leave voice mail? ☐ Yes / No ☐
Office Phone: _____ Leave voice mail? ☐ Yes / No ☐
Email Address: _____
Fax: _____

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

Relationship _____ Name _____ Phone#_____

Relationship _____ Name _____ Phone#_____

Relationship _____ Name _____ Phone#_____

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 no share information with any third party vendors or parties at any time.

Patients Signature: _____ Date _____