

**A. Louis Jimenez, DPM, PC**  
**Gwinnett Foot, Ankle & Leg Center**  
**Jimenez Foot, Ankle & Leg Ambulatory Surgery Center**

2175 North Road  
P.O.Box 527  
Snellville, GA 30078  
(770) 979-0900

3855 Pleasant Hill Rd  
Suite 260  
Duluth, GA 30096  
(770) 497-1017

55 Freedom Pkwy  
Suite 112  
Hoschton, GA 30548  
(706) 658-0003

I, \_\_\_\_\_, have been informed that a copy of A.Louis Jimenez, D.P.M., P.C./Gwinnett Foot, Ankle & Leg Center Notice of Privacy Practices is posted in the office. A copy will be furnished to me upon my request.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

It is out policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail and/or cell phone. However, we will confirm appointments by telephone. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize A. Louis Jimenez, D.P.M., P.C. to leave medical information pertaining to my care by the following methods and will assume responsibility to notify A. Louis Jimenez, D.P.M., P.C., If this information changes.

Home telephone	yes _____ no _____	voice mail	yes _____ no _____
Answering machine	yes _____ no _____	Cell phone/voice mail	yes _____ no _____
Work telephone	yes _____ no _____	Cell phone#	yes _____ no _____
Home address	yes _____ no _____		

Please list names of people with whom we may discuss your medical care:

Spouse name \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Parent name \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

Other name \_\_\_\_\_ yes \_\_\_\_\_ no \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date