G. JASON WILKS, DPM, PCWILKS ADVANCED FOOT CARE**

PATIENT AUTHORIZATION TO LEAVE MESSAGES ON ANSWERING MACHINE/VOICEMAIL AND/OR WITH FAMILY MEMBERS AND FRIENDS AND TO DISCLOSE HEALTH INFORMATION TO FAMILY MEMBERS AND FRIENDS.

Patient Name: _____ Date of Birth: _____

I hereby authorize all of G. Jason Wilks, DPM, PC/Wilks Advanced Foot Care, office staff, healthcare providers, and any agents or independent contractors acting at and under the direction of same to leave a message regarding appointment reminders, test results, or diagnostic results with a designated family member and /or on my answering/voicemail and to disclose any health information to designated family members.

Authorization to leave message on **answering machine/voicemail:** Yes No (Please Circle one)

Authorization to **leave message** with designated names listed below:

Name	Relationship	Phone/Cell
_____	_____	_____
_____	_____	_____

Authorization to **discuss all health information** with designated names listed below:

Name	Relationship	Phone/Cell
_____	_____	_____
_____	_____	_____

RECEIPT OF NOTICE OF PRIVACY PRACTICES AND USE OF TRANSCRIPTION WRITTEN ACKNOWLEDGMENT

I have received or been offered a copy of G. Jason Wilks, DPM, PC's/Wilks Advanced Foot Care Notice of Privacy Practices (NOPP).

To support accurate and efficient record-keeping, we employ an Artificial Intelligence (AI)-assisted system to transcribe and document some of our consultations. This system records then transcribes conversations to create detailed medical notes, which are then reviewed for accuracy. The AI tool adheres strictly to the Health Insurance Portability and Accountability Act (HIPAA) compliance guidelines to ensure your data is secured and protected. Only the healthcare professionals involved in your care will have access to these notes, the same as any other medical record. You have the same rights to these records as otherwise noted in the NOPP. Your participation is completely voluntary. To opt out, please let our staff know and we will make the necessary changes in your chart. By signing below, you acknowledge you have read and understood this information and consent to the use of AI-assisted transcription and documentation.

Please provide the additional information. All information provided on this form will be kept confidential. You have the right to decline to answer these questions.

RACE: ◯ Declined
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ White
◯ Another Race

Ethnic Group: ◯ Declined
◯ Hispanic or Latino
◯ **Not** Hispanic of Latino

Language: ◯ Declined
◯ English
◯ Spanish
Other _____

_____ _____
Signature **Date**

If you are signing as the patient's guardian or legal power of attorney (documentation required):

_____ _____

Print Name

Describe Authority