Consent for Disclosure to Family Member and/or Personal Representative

PATIENT NAME/ID #_____

ADDRESS_____

CITY_____**STATE** _____**ZIP**_____

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for the Georgia Brain & Spine Center, P.C. and Dr. _____ and his/her staff to disclose my personal medical information to the following individual(s):

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Name: _____Relationship to Patient:_____

Conditions for Disclosure (Check the item(s) that apply):

☐ The Practice may disclose my personal health information to the individual(s) above **only** in my presence.

☐ The Practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by telephone, facsimile or e-mail or regular mail.

☐ Other Conditions of Disclosure:

_____

_____

I understand that this consent may be revoked by me at any time by written notice to the Practice.

Patient Signature:_____

Date of Signature:_____

Witnessed by:_____ Title/Position:_____

Print Name of Witness:_____ Date:_____