830 King Avenue Athens, GA 30606
Ins. and Billing Office: 1550 Timothy Road Suite 104 Athens, GA 30606
1000 Cowles Clinic Way Aspen Bldg. 2nd floor Ste A-100 Greensboro, GA 30642
Procedural Center - 1550 Timothy Road Suite 103 Athens, GA 30606
Phone: (706) 425-2400
Fax: (706) 425-2410

Consent for Disclosure to a Family Member and/or Personal Representative

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Athens Spine Center PC, doctors and medical staff to disclose my personal medical information to the following individuals:

Name: ________________________________ Phone: _____________________ Relationship: ________________________

Name: ________________________________ Phone: _____________________ Relationship: ________________________

Name: ________________________________ Phone: _____________________ Relationship: ________________________

CONDITIONS FOR DISCLOSURE:

- ☐ 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 individuals above in discussions in my presence ***and*** when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.
- ☐ Other Conditions of Disclosure:

I understand that this consent is in effect until revoked by me by written notice to the practice.

I understand that by typing my name on the signature line below, I am agreeing to the use of an electronic signature. This signature serves as an affirmative indication that I have carefully reviewed and consented to all the terms outlined in this agreement.

Signed by:____ **Date Signed:**________________________
Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative: ____
[If Signed by a Personal Representative, please state such person's authority to act for the Individual]