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**CONSENT FOR DISCLOSURE  
TO FAMILY MEMBER AND/OR PERSONAL  
REPRESENTATIVE**

PATIENT NAME & ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ 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.

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Printed Name of Witness*

\_\_\_\_\_  
*Date of Signature*

\_\_\_\_\_  
*Title/Position*

\_\_\_\_\_  
*Date*