Print Form

I have agreed to let certain individuals participate in the discussion and decisions to my medical care. Therefore, I hereby give my permission for Atlanta Pediatric Partners, PC to disclose my personal medical information to the following individual (s):

Name:_____ Relationship to Patient:_____

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 during my presence and when I am not physically present, including disclosures by telephone, facsimile, email or regular mail.
- ☐ Other conditions of disclosure:

_____

_____

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

Patient (parent's signature, if under the age of 18 yrs old) Signature:_____

Date:_____

Witnessed by:_____ Title/Position:_____

Print Name of Witness:_____ Date:_____