CONSENT FOR DISCLOSURE TO FAMILY MEMBER
AND/OR PERSONAL REPRESENTATIVE

NORTH ATLANTA ENDOCRINOLOGY AND DIABETES, P.C.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care, Therefore, I hereby give my permission for North Atlanta Endocrinology and Diabetes, P.C. to disclose my personal medical information to the following individual(s):

Name: ______________________________ Relationship to patient: _______________

Telephone #:______________________

Name: ______________________________ Relationship to patient: _______________

Telephone #:______________________

Name: ______________________________ Relationship to patient: _______________

Telephone #: ____________________

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**

OR

- ❑ 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,
- ❑ The practice has my permission to leave detailed messages about my personal health on my home answering machine and/or my cellular voicemail or on the voicemails of any of the individuals listed above.
- ❑ Other conditions of disclosure**:** ____________________________________

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

Patient Signature: ___________________________________ **Date:** ____________

Print Name of Patient:____

Witnessed By: ____ **NAED Employee**

Witness Date: ____