Eastside Chiropractic, P.C.
1011 Woodridge Lane, Building 301
Watkinsville, Georgia 30677
Dr. Bryan Hooper

MEDICAL RECORDS RELEASE

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I give my permission to Eastside Chiropractic to disclose my personal medical information to the following individuals:

NAME: _____

NAME: _____

DATE RANGE OF SERVICE: *FROM:* _____ *TO:* _____

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. This includes disclosures by telephone, fax, 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.

_____ _____

PATIENT SIGNATURE *DATE*