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

MEDICAL RECORDS RELEASE FOR FAMILY MEMBER(S) 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 Eastside Chiropractic 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. This includes 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.

PATIENT SIGNATURE	*DATE*