



**1086 A Baxter Street
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Notice of Privacy Practices

I, _____, acknowledge that I have received the Notice of Privacy Practices.

Signature

Date

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give permission for Athens Neurological Associates, P.C. and Doctor _____ and his/her staff to disclose my personal medical information to the following individual(s).

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 in my presence and when I am not physically present, including disclosures by telephone, facsimile, e-mail or regular mail.

Other conditions of disclosure: _____
