CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE

ANTHONY MEDICAL CLINIC
311 WEST THIRD AVENUE
GASTONIA, NC 28052

CONDITIONS FOR DISCLOSURE:

It is often difficult to talk to patients in person. Therefore, we must have your permission as to how we may communicate with you. Please check if you agree to the following conditions.

____ The practice may disclose my medical information to me and to the following individual(s) in my presence and when I am not physically present, including disclosures by telephone, voice mail, facsimile, e-mail or regular mail.

If you do not agree, please give other instructions:

_____ Other Conditions of Disclosure:_____

_____.

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Anthony Medical Clinic and Dr. William E. Anthony and his staff to disclose my personal medical information to the following individuals:

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____

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

Patient Signature: _____

Print Name of Patient _____

Date of Signature: _____

Witnessed by: _____ Title/Position: _____

Date: _____