HARTWELL FAMILY PRACTICE
HARTWELL, GA

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Consent to Release

This form allows you to decide who you would like for the physicians or their representatives to speak with about your medical care in this office. This includes but is not limited to laboratory results, test results, treatment options and billing information. It also allows you to choose for us to not speak with anyone other than you about your medical care. This includes spouses, parents, and children.

Patient Name: _____

Date of Birth: _____

_____ I DO NOT want my medical information discussed with anyone other than myself.

_____ I give permission for the physicians and their representatives to discuss my medical care as outlined above with the following people:

_____ _____
Name Telephone

_____ _____
Name Telephone

_____ _____
Name Telephone

_____ _____
Name Telephone

I understand that I can change this decision in writing at any time.

_____ _____
Patient or Guardian Signature Date