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**CHILDREN'S PEDIATRIC CENTER: EAST MAIN**

**CONSENT FOR DISCLOSURE TO FAMILY MEMBER AND/OR PERSONAL REPRESENTATIVE**

**Patient Information**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission for Children's Pediatric Center and Dr. \_\_\_\_\_ and the CPC staff to disclose my personal medical information to the following individual(s):

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**Conditions for Disclosure** (check all that apply):

Children's Pediatric Center may disclose my personal health information to the individual(s) above only in my presence.

Children's Pediatric Center 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, fax, mail or email.

Other conditions of disclosure: \_\_\_\_\_

\_\_\_\_\_

**I understand that this consent may be revoked by me at any time by written notice to Children's Pediatric Center.**

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Witnessed By: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Witness: \_\_\_\_\_

Title/Position: \_\_\_\_\_