Atlanta Clinical Care, P.C.

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DISCLOSURE OF INFORMATION

PRIVACY PRACTICE ACKNOWLEDGEMENT

PATIENT RIGHTS

I acknowledge that I have received a copy of Atlanta Clinical Care's Patients' Rights and Responsibilities.

I authorize the physicians and staff of Atlanta Clinical Care, P.C. to disclose my personal medical information to the following individuals:

Name:_____ Relationship_____

Address and Phone:_____

Name:_____ Relationship:_____

Address and Phone:_____

Conditions:

____ The records are to be disclosed only to physicians and medical staff involved in my care, to my insurance companies and to me.

____Other Conditions:_____

_____

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

Signature: _____ Date:_____

Witness: _____ Date: _____