North Fulton Rheumatology, P.C.

Arthritis, Bone and Connective Tissue Diseases

Ciela Lopez-Armstrong, M.D.

CONSENT OF INFORMATION DISCLOSURE

This form is necessary for us to release medical information to your family and friends. If their name is not on this list, we cannot release any information about you to them.

If you do not want anyone to know this information, just strike a line through the blanks and sign the form. THIS FORM MUST BE SIGNED AND DATED. Thank you.

I give North Fulton Rheumatology consent to release: (Please check all that applies)

____ personal
____ financial
____ medical

information to the following person(s):

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Name ______________________________ Relationship ______________

Patient Name Printed ______________________________

Patient Signature ______________________________

Date ______________________________

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