

**FAMILY MEDICAL CENTER OF NE GEORGIA, L.L.C.
555 OLD NORCROSS ROAD, SUITE 100
LAWRENCEVILLE, GA 30045**

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE PROCEDURES:

I consent to the use or disclosure of my protected health information by Family Medical Center, L.L.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care procedures.

I understand that my diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document, and that I have the right to revoke this consent in writing at any time except to the extent that the above named health care provider has taken action in reliance on this consent.

I have reviewed Family Medical Center's Notice of Privacy Practices, which describes the ways in which my health information may be used and disclosed and explains my rights regarding my health information.

Signature of Patient *or* Legal Guardian (if patient under 18)

Printed Name of Patient

Date