GHALY

NEUROSURGICAL *a s s o c i a t e s*

DISCLOSURE TO FAMILY AND FRIENDS

Patient Name____

Date of Birth____

I give full authorization to Dr. Ramsis Ghaly and his staff to discuss my medical information, condition and treatment with the following individual (s):

1. Name____

   Relationship____

2. Name____

   Relationship____

I understand that I may revoke this permission at any time. I also understand that I will be asked to review this permission on an annual basis.

____ Signature of patient or legal representative

___________________________ Date

____ Witness

___________________________ Date

FOX VALLEY OFFICE COMMONS
4260 Westbrook Drive, Suite 127, Aurora, IL 60504
Phone: 630-978-7500 ▪ Voice Mail: 630-978-7583 ▪ Fax: 630-978-7540