



**Permission to share Health Information**

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**No one other than myself, those required by law, or persons indicated below:**

**My Spouse** \_\_\_\_\_  
**Name**

**My Parent** \_\_\_\_\_  
**Name**

**My Child(ren)** \_\_\_\_\_  
**Name**

**My Friend** \_\_\_\_\_  
**Name**

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_