LOUDOUN MEDICAL GROUP / LANSDOWNE FOOT AND ANKLE CENTER

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient name: _____ DOB: _____

Street Address: _____ City: _____ State: ___

Zip: -_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMAIL ADDRESS: _____@_____.COM

I give Lansdowne Foot and Ankle Center permission to leave my results or any pertinent medical information on my voicemail:

(Please circle) YES / NO

(Please circle) Preferred method of contact HOME / CELL

ADDITIONAL CONTACT INFORMATION

I hereby authorize this office and any of its employees to use or disclose my patient health information to the following person(s), entities, or business associates of this office:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

My signature verifies that this request accurately reflects my wishes. I understand that this form is valid for 1 year from the date of signature. It is my responsibility to notify Lansdowne Foot and Ankle Center of any changes prior to the expiration of this form.

_____ _____

Signature Date

I understand that I have the right to: Revoke this authorization at any time by giving written notice to the office, inspect a copy of patient health information being used for disclosure under federal law, refuse to sign this authorization, receive a copy of this authorization and restrict what is disclosed.

As required by the privacy regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.