LOUDOUN MEDICAL GROUP / LEESBURG STERLING FAMILY PRACTICE

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB**: _____

Street Address/PO Box: _____**City:** _____**State:** ____ **Zip:**_____

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

EMAIL ADDRESS: _____@_____

Patient Portal: ***(Please circle)*** **SIGN ME UP! ALREADY ENROLLED NOT INTERESTED**

Preferred method of contact for ***appointment reminders: (Please circle)*** **TEXT CALL EMAIL**

I give Leesburg Sterling Family Practice permission to leave my results or any pertinent medical information on my home voicemail or my cell phone: ***(Please circle)*** **YES or NO HOME / CELL / BOTH**

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	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

My signature verifies that this request accurately reflects my wishes. I understand that this form is valid for 1 YEAR from date of signature. It is my responsibility to notify Leesburg Sterling Family Practice 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