LOUDOUN MEDICAL GROUP-MOUNTAIN VIEW MEDICAL ASSOCIATIONS
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Date:_____

Patient Name:_____DOB:_____

Address:_____

Home #:_____ Cell#_____ Work#_____

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 with out your authorization.

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), entity(s), or business associates of this office:

Name	Phone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

I give Mountain View Medical Associates permission to leave my results or any pertinent medical information on my home voicemail or my cell phone. *Please circle: YES NO*

My signature verifies that this request accurately reflects my wishes. I understand that this form is valid for one year from date of signature. It is my responsibility to notify Mountain View Medical Associates 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 with this authorization.

REFUSAL TO SIGN ONLY

I understand that if I do not sign this document it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Refusal to Sign Signature_____ Date:_____

Witness Signature:_____ Date:_____