



**LOUDOUN
INTERNAL MEDICINE**
ASSOCIATES

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Permission to Disclose Information

I, _____, acknowledge that I was made aware of the Loudoun Internal
(print patient name)

Medicine Associates Privacy Policy and a copy was made available to me for my review.

I authorize Loudoun Internal Medicine Associates to disclose my protected health information to the following person(s) and entities:

Name	Date of Birth	Relationship to You

Printed Patient Name

Today's Date

Patient Signature

Printed Name of Personal Representative

Relationship to Patient

Signature of Personal Representative

Notification of Test Results

In most cases, you will be notified by phone of your test results. Please ensure the phone number we have on file for you is correct.

Preferred phone number: _____

May we leave a detailed message at this number? Yes No