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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 Police	ey and a copy was made a	vailable to me for my review.	
I authorize Loudoun Internal Medand entities:	icine Associates to disclo	se my protected health information	n to the following person(s)
Name	Date of Birth	Relationship To You	Phone #
Printed Patient Name		Today's Date	
Patient Signature			
Distant		District District	
Printed Name of Personal Representative		Relationship to Patient	
Signature of Personal Representati	ve		
	Notification	of Test Results	
In most cases, you will be notified is correct.	by phone of your test res	sults. Please ensure the phone num	nber we have on file for you
Preferred phone number:			
May we leave a detailed message a	ot this number? \(\sum_{\text{Vas}}	□ No	