Loudoun Gastroenterology

Authorization to Disclose Health Information

I ____________________________________ authorize Loudoun Gastroenterology to disclose my patient health information to the following person (s) or entities.

I understand that this is form will be valid until I _________________________________ revoke this authorization by giving a written notice the office.

Name	**Phone Number**	**Relationship**
____________________________________	_____________________________	_______________
____________________________________	_____________________________	_______________
____________________________________	_____________________________	_______________

My signature verifies that this request accurately reflects my wishes. I understand that I have the right to Revoke this authorization at any time.

____ _______________

Signature **Date**