



211 Gibson Street, NW · Suite 215 · Leesburg · VA · 20176

Phone: (571) 707-2085

Fax: (571) 291-9196

AUTHORIZATION TO DISCLOSE INFORMATION

Patient's Full Name _____

SS# _____

Date of Birth _____

**INSTRUCTIONS FOR LEAVING MESSAGES
AND/OR DISCLOSING YOUR PERSONAL HEALTH INFORMATION**

OK to communicate with spouse? YES NO

Spouses Name _____

OK to leave information on answering machine? YES NO

OK to communicate with parent/children? YES NO

Name(s) _____

OK to communicate with caregiver? YES NO

Name _____

OK to communicate with any other person(s) YES NO

Please list _____

Communicate only with me YES NO

THIS DIRECTIVE WILL BE CONSIDERED IN EFFECT UNTIL REVISED IN WRITING

Signature _____

Date _____

Other Comments _____

