UROGYNECOLOGY CENTER
NORTHERN VIRGINIA

## PERMISSION TO DISCLOSE INFORMATION

I, _____, acknowledge that I was made aware of Urogynecology Center of Northern Virginia/Loudoun Medical Group's Privacy Policy and a copy was made available to me for my review.

I authorize Urogynecology Center of Northern Virginia 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