HealthVisionsMD, Inc.
1230 Alverser Drive, Suite 100, Midlothian, VA 23113
804-893-7800 Fax: 804-893-7801

Authorization to Disclose Personal Health Information

Patient Name: _____ DOB: _____

By signing this document, I give permission to the designated person(s) listed in the table documented below to receive Private Health Information or other authorization as listed in the comments section. I understand this form is legally binding and that I may revoke my authorization at any time by submitting by request to change, add, or terminate such permission in writing.

Date Permission Granted	Name of Individual	Comments or Instructions	Patient Initials	Date Permission Revoked	Patient Initials	Telephone Number

To ensure the designated person(s) may obtain information by telephone, the party calling HealthVisionsMD must be able to share the patient identifier/password with the HealthVisionsMD staff.

Patient Identifier/Password: _____

_____ _____
Printed Name - Patient / Authorized Representative Signature - Patient / Authorized Representative

_____ _____
Authorized Representative's Relationship to the Patient Date

If you are signing on behalf of a minor, incapacitated or otherwise legally dependent patient, please indicate your relationship to the patient. By signing this form as "Authorized Representative" on behalf of the patient, you represent to HealthVisionsMD that you have legal authority to act on behalf of the patient.