Dear Patient,

HIPAA regulations prohibit your Physician from sharing information regarding your medical care with other family members or friends, unless prior authorization by the patient is given.

I, _____, authorize the doctors of Loudoun Walk In Medical Center to disclose my medical information to the following family members or close friends listed below who assist in my care.

	NAME:	**RELATION:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	☐ ANY DOCTOR / _____	

_____ _____

Patient Signature Date

* Please be advised that it is your responsibility to keep this information up to date regarding adding or removing names from your disclosure list.

Version 2 dated 29-OCT-2016