# Family Physicians of Old Town Fairfax

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## Privacy Policy

Patients Name:_____

Address:_____

City:_____State:_____Zip:_____

I authorize Family Physicians of Old town Fairfax and any of it's designated staff and physicians, to discuss any protected health information pertaining to my medical and/or financial history, including prescriptions and appointments to the following people/entities:

Name:_____

Relationship to Patient:_____

Name:_____

Relationship to Patient:_____

Name:_____

Relationship to Patient:_____

Name:_____

Relationship to Patient:_____

If, at any time, I wish to revoke this request I must do so in writing.

Patient's Signature_____ Date_____