MARIJA PETROVIC MD, LLC

Marija Petrovic MD, LLC
3615 Chain Bridge Rd, Unit I (Eye)
Fairfax, VA
22030

REQUEST/CONSENT TO DISCLOSE HEALTH INFORMATION

Patient Name:_____
DOB:_____

I hereby request that health information be discussed with and disclosed to the family member(s), relatives, or friends listed below. The individuals identified below are involved in my care and/or payment for my care, and I agree that Marija Petrovic M.D. may share such information as she deems relevant to my care (e.g., appointment times, required care and diagnoses).
I understand that I have the right to revoke this request/consent by delivering written notice to Marija Petrovic M.D.

Please list the individual's name and relationship to you:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient or Legal Guardian Date