Marija Petrovic MD, LLC
3615 Chain Bridge Road, Unit I (Eye)
Fairfax, VA 22030
703-582-0010

Authorization to Disclose or Request Protected Health Information

Patient Name: ___________________________________ Date of Birth: ________________
Address: ____
I authorize Marija Petrovic MD, to exchange with, release to, and receive from the following Provider/Organization/Individual information concerning the above-named patient:
Name: ____
Address: ____
City/State/Zip: ____
Telephone Number: ____
Information to be released: ____
This authorization is in effect for the time period from _______________ to ________________.
This authorization allows the indicated providers to share information described above for ongoing use or disclosure during the time period specified above. The purpose of this disclosure is at the request of the client/patient or authorized representative.
______These records are not protected by Federal Drug and Alcohol Confidentiality Regulations (42 CFR Part 2).
______ These records are protected by 42 CFR, Part 2. I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
I understand that:
-service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure outlined above.
-I may revoke this authorization at any time by submitting a written statement of revocation to Marija Petrovic MD, except to the extent that Marija Petrovic MD, already has taken action based on this authorization.

____ ______________________

Signature of Patient/Parent/Authorized Representative Date