

Please provide the name(s) of person(s) if any, to whom you would like Adult and Pediatric Urologists of Northern Virginia, Ltd. to allow disclosure of personal information. Please also specify information that may be disclosed (i.e., test results, appointment information, etc). You may also indicate "All", if appropriate.

Name	Relation (Spouse, Friend, etc)	Allowed Disclosures

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name