Name of provider/facility:

□ MWH □ Stafford Hospital □ FASC
□ Mary Washington Healthcare Physicians □ Other

I, _____, hereby request that health information be discussed with and disclosed to the members, relatives, or friends listed below. The individuals identified below are involved in my care and/or payment for my care, and I agree that the provider listed above may share such information as the provider may deem relevant to such individual's involvement, including appointment times, required care and diagnosis. I understand that I have the right to revoke this request/consent by delivering written notice to the provider.

Please list individuals: Phone Number:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

_____ _____ _____
Patient or Legal Surrogate Date Relationship to Patient

_____ _____
Witness Date

R05830

Mary Washington Healthcare

Consent to Disclose Health Information
FR-1429-MWHC Rev 11/2019

PATIENT IDENTIFICATION
1 ¼" X 3