Virginia Center for Medicine
43490 Yukon Dr. #210
Ashburn, VA 20147
(703) 726-2566

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Patient's Name: (Last)_____ (First)_____

Date of Birth: _____

I give permission to the following individual(s) to discuss my medical information with Dr. Harneet Kohli's office. I also authorize them to make and cancel appointments on my behalf.

Printed Name	**Relationship to Patient**	**Telephone Number**

I understand that this authorization will be valid (Choose One)

☐ **Indefinitely**

☐ **Until this date** _____

I may revoke this authorization at any time **in writing**.

Patient's Signature: _____ Date: _____