Partners

Steven W. von Elton, M.D. David C. Evans, M.D. Christopher M. Ward, M.D. Gregory S. Golub, M.D. Ash B. Diwan, M.S., M.D.



Providers

Kimberly S. Arnstine, M.D.
Joanna Barefoot, C.D.E.
Alicia Fridgen, P.A.C.
Angelina Harman, F.N.P.
Julie Ives, P.A.C.
Jorge Minera, M.D.
Valerie Oare, F.N.P.
Bhavika Panchal, F.N.P.
Amy L. Trace, M.D.

493 Blackwell Road, Suite 202, Warrenton, Virginia 20186 Tel: (540) 347-4400 Fax: (540) 341-7509

Authorization for Release of Information

I hereby authorize:		
To disclose the following protected health in The information to be disclosed should include:		NT FAMILY PRACTICE.
☐ Any or all information in my me☐ Information limited to dates of so☐ Information limited limite	dical record my physician ervice before	
Services related to the following		
Do not send any information relating to: □ AIDS, ARC, or HIV Infection □ A	lcohol or Drug Abuse	☐ Mental Health Disorders
This authorization shall be in force and effective Revoked by me The following specific date: The following:		
At which time this authorization to use or di	sclose this protected heal	Ith information expires.
Signature of Patient or Personal Representat	tive	Date
Printed Name of Patient or Personal Represe	entative	
(for identification purposes only, please incl	ude following informatio	on on the patient)
Patient's Name	Date of Birth	n SSN
Address	City	State Zip