# *SURGICAL SPECIALISTS OF NORTHERN VIRGINIA*
# *BREAST CARE CONSULTANTS OF NORTHERN VIRGINIA*

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**I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION VIA FAX AS MAY BE DEEMED NECESSARY BY MY PHYSICIAN, WITH REGARD TO MY MEDICAL CARE.**

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**SIGNATURE OF PATIENT DATE**

## ***ELECTIVE AUTHORIZATION***

*****I AGREE TO ALLOW YOU TO SPEAK TO THE FOLLOWING FAMILY MEMBERS OR ACQUAINTANCES CONCERNING MY MEDICAL CARE. YOU MAY CORRESPOND WITH THEM EITHER IN PERSON, VIA PHONE OR MAIL.**

| NAME | RELATIONSHIP | PHONE # |
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**SIGNATURE OF PATIENT DATE**