



DR. ELENI SOLOS-KOUNTOURIS, P.C.
ELENI SOLOS-KOUNTOURIS, M.D., F.A.C.O.G.

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“Providing high quality healthcare for all stages in a woman’s life”

**AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION
AND
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____
(Name of Patient or Patient Representative)

hereby authorize Dr. Eleni Solos-Kountouris, P.C., the use or disclosure of all the information contained in the patient record of

(Name of Patient)

for any reason concerning treatment, payment, or health care operations.

I acknowledge receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information on how the confidential information in my patient record may be used and disclosed by the practice.

I understand that the practice reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. A copy of any revised Notice of Privacy Practices will be available to me upon request.

I understand that:

1. This authorization is valid until it is revoked by me.
2. I have the right to revoke this authorization at any time by giving written notice of my desire to do so.
3. I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose the information in the patient record.
4. I need to request the revocation in writing to the physician’s office.

I understand that I have the right to restrict how the practice uses or discloses the information in my patient record. I also understand that the practice does not have to agree to such restrictions, but once such restrictions are agreed upon, the practice and their agents must adhere to such restrictions.

Signed: _____ Date: _____

Relationship to Patient: _____