



**Arjun Medical Center, PC**  
7350 Heritage Village Plaza, Suite 101  
Gainesville, VA 20155  
Ph: 571-248-6666 Fax: 703-202-8594

## PRIVACY DISCLOSURE FORM

Arjun Medical Center, PC respects your right to privacy. You, as a client, have the right to make certain choices about the uses and disclosures of your health information. Any information you authorize for use and disclosure may be re-disclosed and is no longer protected. You may amend your selections for restrictions by contacting the Privacy Officer.

I authorize and consent to the release of my health information to the following individuals:

Names of Person or Persons

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I would like to receive all written communications at the following location rather than my home address (If none specified, written communication will be forwarded to your home address):

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P.O. Box or Street Address, City, State, Zip

I would like to receive appointment reminders and patient care follow-up communication only by the following means (check all that apply):

E-Mail \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**NOTE: Arjun Medical Center, PC reserves the right to implement stricter privacy standards under certain circumstances which it deems necessary for the protection of the patient.**

I acknowledge that I have been given the Arjun Medical Center, PC Privacy Act Practice and have had an opportunity to ask questions about the information provided in the notice. I understand that I have the right to request other reasonable requests regarding confidential communications by contacting the Privacy Officer as specified in the **Notice of Privacy Practices**.

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SIGNATURE OF PATIENT OR PATIENT  
REPRESENTATIVE

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DATE

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PRINTED NAME OF PATIENT OR  
PATIENT'S REPRESENTATIVE

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RELATIONSHIP

Effective 1/1/2008