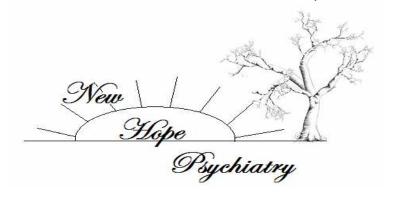
NEW HOPE PSYCHIATRY, PLLC



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REQUEST/CONSENT TO DISCLOSE HEALTH INFORMATION

Patient Name:_____SSN:____

I hereby request that health information be discussed with and disclosed to the family member(s), relatives, or friends listed below. The individuals identified below are involved in my care and/or payment for my care, and I agree that Wayne Chang M.D. may share such information as he deems relevant to my care (e.g., appointment times, required care and diagnoses).	
I understand that I have the right to revowritten notice to Wayne Chang M.D.	oke this request/consent by delivering
Please list the individual's name and rel	ationship to you:
Name	Relationship
Signature of Patient or Legal Guardian	Date