Karin Varblow, MD, PC

1489 Chain Bridge Rd, #203
McLean, Virginia 22101
703-996-4737
www.drkarinmd.com

Authorization for the Release of Information

I, _____ (print full name), hereby authorize and give consent for the exchange of information between Karin Varblow, MD

And

_____ (name)

_____ (email)

_____ (phone)

Regarding my personal health information or that of my child, _____, for the purpose of evaluation, treatment, and coordination of care.

This authorization for the release of information will expire on _____ (date) or 90 days after the termination of treatment, whichever comes first.

Signature: _____

Date: _____