Allergy and Asthma Center
Anita N. Wasan, MD, PLC
6824 Elm St, Ste 120
Mclean, VA 22101
Tel: 703-992-7065, Fax: 703-992-7063
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Release of Medical Information

____
Patient Name DOB

____
Address

____
City, State, Zip

____________________ ____________________
Telephone Number (Mobile) Social Security Number

I authorize the release of my medical records to:

____

My medical records are to be released from:

____

Dates of treatment:____________________Send via:____________

Record Content:____________________________________

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by myself at any time except to the extent that the action has been taken in reliance upon it. I acknowledge and hereby consent that the released information may contain HIV testing, HIV results, and/or AIDS information. This facility (Anita N. Wasan MD PLC) is released and discharged of any liability , and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Date______________Relationship of Undersigned to patient:____________

Signature____________________________________