Allergy & Asthma Center
Anita N. Wasan, MD, PLC
6824 Elm Street, Suite 120, McLean, VA 22101
Tel: 703-992-7065, Fax: 703-992-7063
www.novaallergy.com

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:

_____

Date 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 I understand that this consent may be withdrawn by myself at any time except to the extent that the action has been taken in reliance upon it.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. The 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: _____