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

Release of Medical Information

_____

Patient Name DOB

_____

Address

_____

City, State, Zip

_____

Telephone Number (Mobile)

I authorize the release of my medical records to: (PLEASE DO NOT FILL OUT)

_____

My medical records are to be released from: (PLEASE DO NOT FILL OUT)

_____

(OFFICE STAFF TO FILL OUT REQUEST)

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 I understand that this consent may be withdrawn by myself at any time except to the extent that the action has been taken in reliance upon it.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