

Allergy and Asthma Center
Anita N. Wasan, MD, FAAP, FAAAAI
Lauren H. Vogan, PA-C

PRIVACY AND CONFIDENTIALITY RELEASE OF INFORMATION

- 1) I give permission for Dr. Anita Wasan or staff to discuss my treatment with my spouse/partner/family members about my presence in the office. Such discussion may include my diagnosis and treatment.

YES _____

NO _____

Names of person (s) I designate:

- 2) I give permission for Dr. Anita Wasan or staff to discuss my appointments, my treatment, or test results I have had with the above person (s) I have designated when I may/may not be present.

YES _____

NO _____

- 3) I give permission for Dr. Anita Wasan or staff to leave messages for me regarding appointments or test results on the answering machine on the telephone number below which I designate.

YES _____

NO _____

Telephone number to leave message is:

I can revoke this authorization at any time in writing.

Patient Signature: _____

Date: _____

Witness: _____