Allergy and Asthma Center
Anita N. Wasan, MD, FAAP, FACAAI

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: _____