Allison Win, M.D., LLC.
2401 Research Blvd, STE # 102, Rockville MD 20850.
Phone: 240-224-7519 Fax: 240-224-7596
www.allisonwinmd.com

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Authorization to Release Information

Patient Name: _____

Date of Birth: _____

Please initial the information that you authorize the office of Allison Win, MD, LLC including all physicians from the office and/or the staff to release to person(s) listed below:

_____ All medical Information _____ Appointment Date/Time

_____ Billing Information _____ Others_____

1. I authorize the above information to be release to (family Members, Doctors, and Lawyers, except as allowed by Law).
2. If NONE, Leave blank and sign below:

Name: _____ Relationship: _____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

This authorization is subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosure party. Written revocation will be effective upon receipt but will not be effective to the extent that the office of Allison Win, MD, LLC including all physicians from the office and/or the staff have acted in reliance upon this Authorization.

I understand that the Office of Allison Win, MD, LLC including all physicians from the office and/or the staff may not lawfully disclose any health information to others unless another written authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Signed: _____ Date: _____

Relationship if other than Patient: _____