# Ashburn Sterling Doctors PLLC/Maria Wasique, M.D.

## Authorization for Use and Disclosure of Health Information

Patient Name: Date of Birth
Previous Name:

By signing this form, I hereby authorize ___________________________________ to disclose the health information described below to Dr. Maria Wasique, 21785 Filigree Ct. Suite 215 Ashburn, VA 20147.

**(Check All That Apply):**

- ☐ All health information
- ☐ Health information relating to the following treatment of condition

______________________________________________________________________________
______________________________________________________________________________

- ☐ Health information for the date (s) ____________________________________________________

______________________________________________________________________________

- ☐ Other specific description_____________________________________________________________

**Reason for This Authorization**

- ☐ At my request
- ☐ Other (specify) Dr. Wasique is my Primary Care Physician
- ☐ ______________________________________________ has requested this authorization for marketing purposes and (will/will not) receive compensation from a third party.

**This authorization expires upon**

______________________________________________________________________________
(date or description of event)

I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization if to do so would be prohibited by federal or state law. I understand an authorization may be required to participate in research or where health care services are provided solely for the purposes of creating health information for a third party, and that if I refuse to sign an authorization those services may be denied.

I may revoke this authorization in writing. I if do, it will not affect any previous actions already taken in reliance upon my authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested, to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

_________________________________ _______________
Patient/Legally Authorized Representative Date

_________________________________ _______________
Printed Name Relationship to Patient