ALLERGY AND ASTHMA ASSOCIATES
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AUTHORIZATION FOR MEDICAL RECORD INFORMATION RELEASE

Patient Name: _____/Date of Birth: _____

Address: _____ /Phone: _____

_____

I hereby authorize _____ to release my medical records and any other medical information necessary for the purpose of further healthcare or insurance needs.

Records to be sent to: _____
_____
_____
Phone: _____
Fax: _____

I WISH MY RECORDS TO BE: ☐ MAILED ☐ FAXED ☐ WILL BE PICKED UP

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments

_____ Record of visit for a specific date or dates limited to:_____

_____ Copies of records or reports provided to the above named (i.e. hospital, lab)

_____ All of the above

_____ Records of visits (all visits)

_____ Other_____

I understand that I am responsible for its contents and am in no way holding the above responsible for the disclosure of information revealed in the enclosed medical records. This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, is confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date it is signed, or sooner if noted below.

_____ _____
Patient (or guardian if a minor) Date

_____
Revocation date (if other than 60 days from date above)

_____ _____
Witness Date

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The information below is being requested for internal use only for statistical purposes. We would appreciate your completing the information, however, you are not obligated to do so.

Reason for Transfer: (**PLEASE** check applicable reason)
_____ Transferring Allergy/Asthma Care to another physician
_____ My insurance has changed and I have changed providers
_____ Moving out of area or more convenient Allergy Practice
_____ Other (Please Briefly Explain) _____

_____