Advancements in Allergy and Asthma Care, Ltd.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:

Name_____ Date of Birth_____
Address_____
City_____ State _____ Zip _____Day Phone_____

Clinic: Information released from:

Clinic Name _____
Provider Name _____ Phone _____ Fax _____
Address _____
City _____ State _____ Zip _____

Recipient: Information released to:

Clinic Name _____
Provider Name _____ Phone _____ Fax _____
Address _____
City _____ State _____ Zip _____

Information to be disclosed: Date/timeframe of information requested: _____

- ❑ Clinic Visit Notes
- ❑ Special Tests/Testing_____
- ❑ Consultation/follow-Up Reports
- ❑ Immunizations _____
- ❑ Occupational Health/Worker's Comp
- ❑ X-Ray Report/Mammography Report
- ❑ Lab Reports
- ❑ X-Ray Films
- ❑ Hospital Records
- ❑ Mental Health/Psychological Testing/ Reports
- ❑ Other _____
- ❑ All of the above (including records relating to communicable disease and/or those marked confidential).

*Information in your chart that was not originally generated by Advancements in Allergy and Asthma Care, LTD. will not be released to another facility. Such information must be obtained from the original source.

Reason for release:

- ❑ Legal
- ❑ Consult/Second Opinion, Personal
- ❑ Insurance Claim Report
- ❑ Insurance Changed to: _____
- ❑ Out of Town Move
- ❑ Selected New Physician
- ❑ Referred by Dr. _____

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature. I do not authorize further release to any third party. I understand that once information is released under this authorization, clinic and their employees and my physician(s) cannot prevent the re-disclosure of that information. I understand it is voluntary to sign this authorization.
Authorization: I authorize the above provider to release the information marked above to the recipient.

_____ _____
Signature of Patient/Guardian Relationship to Patient if not signed by Guardian

_____ _____
Date of Patient's Signature Reason Patient unable to sign