ALLERGY PARTNERS

Address: _____

City, State Zip: _____

Phone: _____ **Fax:** _____

MEDICAL RECORDS RELEASE AUTHORIZATION

Date: _____

I hereby authorize Allergy Partners, d/b/a Allergy Partners of _____, to release any information for the purpose of medical care, including but not limited to: diagnosis, blood and X-ray reports, examination findings, etc., from the period: _____ to _____ **to**:

Send Records To Name:_____

(Name of person or facility Allergy Partners to Send Records To)

Address: _____

Phone: _____ **Fax:** _____

I have read and understand this authorization, and authorize use and disclosure of health information about the named patient in this authorization. I understand that providing this authorization for the requested use and disclosure is not a condition of my treatment, payment, enrollment in a health plan, or eligibility for benefits. This authorization will expire six months after the above date, or automatically when the records on this authorization have been received.

Special Authorization: My evaluation, diagnosis, and/or treatment may be released to the requestor noted above by my initials next to the information to be released.

_____ Behavior Health _____HIV/AIDS _____Alcohol &/or drug abuse or dependence

Requested Health Information:

- ☐ Hospital Records: _____
- ☐ Clinic Notes / Office Visit Notes
- ☐ Immunotherapy Testing
- ☐ Extract formulation
- ☐ Pulmonary Function Test(s)
- ☐ Allergy Injection Record
- ☐ Pathology Reports
- ☐ Biopsy Results
- ☐ Blood Tests
- ☐ Radiology Reports
- ☐ Methacholine Challenge
- ☐ Echocardiogram / Stress Test
- ☐ Sleep Study Report
- ☐ 24hr pH Probe Reports
- ☐ All Office Records
- ☐ Include records we have received from other medical providers
- ☐ Other (i.e. financial)_____

_____ _____/_____/_____

Print Patient Name Patient Date of Birth

_____

Address

_____

Signature

_____

Personal Representative / Relationship to patient or other authority

I have the right to revoke this authorization at any time except to the extent that action has been taken in reliance on the authorization. To revoke I must submit a written request to the Attention of the Privacy Officer at the address stated above. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations).