ALLERGY ASTHMA CLINIC, LTD **MEDICAL RECORDS RELEASE**

PATIENT NAME: _____ DOB: _____

PATIENT SS #: _____ PHONE**:** _____

SEND RECORDS <u>FROM</u>: _____
Facility/ Physician Name

_____
Address

_____
City State Zip

_____
Telephone Number Fax Number

I hereby authorize and request the release of the following information:

_____ Last 3 visits, current labs, allergy testing, immunotherapy records and PFT's

_____ PATIENT INFORMATION FOR VISIT DATE(S) _____ TO _____

_____ OTHER (specify) _____

SEND RECORDS <u>TO</u>: _____
Facility/ Physician Name

_____
Address

_____
City State Zip

_____
Telephone Number Fax Number

I understand that once the healthcare provider provides the information that I am authorizing and requesting to be released to Third Parties, the healthcare provider has no control over the information provided to the patient or third parties. The individual or organization that I authorized to receive the information might disclose it or fail to ensure the information remains confidential and federal or state privacy laws may no longer protect the information. I agree that Allergy Asthma Clinic,Ltd is released from any and all liability or responsibility regarding information released to the patient or Third Parties pursuant to patient authorization to release such information.

This Authorization is valid for one year from the date of signature, and a copy of this Authorization is as valid as an original.

Signature: _____ **Date**: _____

Relationship to patient (if parent or guardian): _____

FOR OFFICE USE ONLY: RECORDS SENT VIA _____ BY _____ ON _____.