

Authorization to Release Medical Records

Date: _____
Patient Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____

I authorize to disclose the following medical information *to*:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

I authorize to disclose the following medical information *from*:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

This authorization extends only to documents initialed below:

____ Progress Notes
____ Consultation Reports
____ History and Physical Examination
____ Lab Results Type of test: _____ Date: _____
____ X-Ray Reports Date taken: _____ Date of discharge: _____
____ Mental Health and/or alcohol and drug abuse treatment
____ AIDS/HIV/Hepatitis Information
____ Other (Must be specific) _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization.
2. A photocopy of fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for sixty (60) day period from the date it is signed.
4. Allergy and Asthma Consultants, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Print Patient's Name

Patient's Signature (or Guardian, if minor)

Date