



ASTHMA & ALLERGY
SPECIALISTS, PA

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____ Account #: _____

I, _____, authorize the release of medical records and would like those records to be transferred to Asthma & Allergy Specialists.

I, _____, authorize the release of medical records and would like those records from Asthma & Allergy Specialists to be copied and transferred to the address below. I also understand that there will be a \$10.00 fee for the copy of my records. This will be paid at the time the copying is done.

- ◆ I understand that the medical records, which I have requested to be released, may contain information regarding mental illness HIV/AIDS and/or substance abuse (drugs and/or alcohol). I further understand my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I do not authorize release of information related to AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus) infections.

I do not authorize release of information related to psychiatric care and/or psychological assessment.

I do not authorize release of information related to treatment for alcohol and/or drug abuse.

- ◆ The specific health information to be released includes (please check the appropriate box below):

Entire Record (including records of other providers)
 Entire Record (excluding records of other providers)
 Discharge Summary
 History & Physical
 X-Ray
 Progress Note
 Consults
 Lab
 Other (please specify): _____

Dates of Service: _____

- ◆ The above information is released for the following purpose (please check the appropriate box or boxes listed below) and that purpose only. Any other use is prohibited without the specific written consent of the patient or authorized legal representative.

Physician Request
 Insurance Request
 Personal
 Legal
 Child/Adult Protective Services

Transfer Medical Care to:

Name: _____

Address: _____

Phone #: _____ Fax #: _____

Other: _____

- ◆ I hereby acknowledge this consent is voluntary and is valid until such request is fulfilled but not to exceed 90 days from the date signed. I release, discharge and agree to hold harmless all parties to whom this consent is given from any liability that may arise from the release of information as authorized above. I may revoke this request, in writing, at any time except to the extent that action based on this consent has taken place. I understand that a photocopy of this authorization is considered acceptable in lieu of the original.

Signature of Patient or Authorized Legal Representative

Witness/Asthma & Allergy Specialists employee

Relationship of Authorized Representative to Patient

Date: _____ Time: _____ AM / PM