C. Thomas Humphries, MD, MBA
Hugh R. Black, II, MD
William S. Ashe, Jr., MD
Melanie D. Sullivan, MSN, FNP-C
Sary L. De La Rosa, MSN, FNP-C

ASTHMA & ALLERGY SPECIALISTS, PA

Ph: (704) 341-9600 • Fax: (704) 341-9996

8045 Providence Rd.
Suite 300
Charlotte, NC 28277

10310 Mallard Creek Rd.
Suite 101A
Charlotte, NC 28262

13557 Steelecroft Pkwy
Suite 2200
Charlotte, NC 28278

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 a 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 it in the regulations.

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

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

I ☐do ☐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 (<u>including</u> records of other providers. ☐ Entire record (<u>excluding</u> records of other providers)

☐ Discharge Summary ☐ History & Physical ☐ X-Ray ☐ Progress Note ☐ Consults ☐ Lab

☐ Other (Please specify): _____

Date(s) of service: _____

● The above information in released for the following purpose (please check the appropriate box/boxes listed below) and that purpose only. Any other use is prohibited without 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: _____Suite: _____

City: _____State_____Zip: _____

Phone: _____ Fax: _____

☐ Other: _____

I hereby acknowledge this consent is voluntary and is valid until such request in 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 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

_____ _____ _____AM/PM

Relationship of authorized representative to patient | Date | Time