AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: ____

Birthdate: ______________________ Former/Maiden Name: ______________________________
(if applicable)

Address:____

City, State, Zip: ____

Phone: _____________________________

Authorization to: **Release Medical records FROM Asthma & Allergy Associates to:**

Name____

Address:____

City, State, Zip____

Phone:____________________________**Fax:**____________________________________

Requested Items (Please check all that apply)

_____Office Notes **_____Extract Recipe**
_____X-Ray Reports **_____Injection Records**
_____Skin Test Sheets **_____All Records**

Reason for Release:____

A copy of this authorization may be used with the same effectiveness as the original. I hereby release the receiving and/or releasing parties from any liability, which may result from furnishing the information requested. This release will remain in effect for 180 days unless revoked in writing at an earlier time.

Signature of the patient is required of all patients' 18 years of age or older. A parent or legal guardian must sign if the patient is a minor.

____ ___________________________________
Signature of Patient /Guardian Witness

____ ___________________________________
Relationship to Patient Date

Please be aware that there is a fee for the release of medical records, except to physicians' offices. If they are being released to the patient or legal guardian, or attorney, the fee will be $16.50 for the first 10 pages and $0.75 per page for pages 11-40 and .50 per page thereafter. Insurance Companies and SSA– pay a flat fee of $35.00.