AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient name: ______________________ Former/Maiden name: _____________________
(if applicable)

Birth date: _______ - ______ - _________

Address: ____________________________ City, State: ___________________ Zip: __________

Phone: (________) _________-____________

Authorization to: **RELEASE Medical Records TO Asthma & Allergy Associates**, from:

Name of Physician: ____________________________________

Name of Practice: ______________________________________

Mailing Address: _______________________________________

City, State: _____________________________, ________ Zip: _________-________

Fax:______________________________________

Requested Records to be released (be specific): - Evaluation & Treatment Summary

- All records available (E&M Services, notes, X-rays, test results, correspondence, etc).

- X-Ray Reports - Skin Test Results - Lab Reports

-Extract Recipe - Injection Records - Consultation Reports

- Other: (please list here) ____

I hereby release the receiving and releasing parties from any liability which may result from furnishing the information requested. This release will only remain in effect for 180 days (*from date of signature below*) unless revoked in writing at an earlier time.

Signature of Patient *(Guardian of minor child patient)*: ________________________________

Date: ________________

Witness to the above signature: ______________________ Sign: ________________________
(Print name)

A copy of this authorization may be used with the same effectiveness as the original.

Send records to: **Asthma & Allergy Associates, PC**
2709 N. Tejon Street
Colorado Springs, CO 80907

Attn: Medical Records Section