Allergy & Asthma

DIAGNOSTIC OFFICE

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PATIENT AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT NAME: ____________________

Patient Complete Address: ____________________

Birthdate: ____________________ Phone #: ____________________

The purpose of this release information for:

- ☐ Transfer of Records to another Provider for **Transfer of Care**
  - ***Reason for transfer*** ____________________
- ☐ Copy of Records to another Provider for treatment~ Continuity of Care
- ☐ Attorney
- ☐ Insurance Claims Information
- ☐ Other (Describe) ____________________

Specific information to be released:

☐ Medical Record from ____________ to ____________

☐ Entire Medical Record, including patient histories, office notes, test results, radiology studies, consults, billing records, insurance records, and records sent by other health care providers.

☐ Other: ____________________

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**** Authorization to Discuss Health Information:**

By initialing here _____ (Initial), I authorize the Allergy & Asthma Diagnostic Office to discuss my health information with:

____________________ Name of Individual

____________________ Relationship to Patient

Release Information To:

Name: ____________________

Address: ____________________

Phone#: ____________________ Fax#: ____________________

I understand the following (Please initial all statements)

_______ I understand that I am authorizing the use of my individually identifiable health information. I understand that if my health information is used or disclosed, the information released may no longer be protected by HIPAA privacy regulations.

_______ You may be charged up to $0.75 per page for records. If information is to be mailed, there will be a charge for the cost of mailing.

_______ I understand that I have a right to refuse to sign this release, however my information will not be sent to the requesting agency.

_______ This Authorization of Release will expire in 1 year (365 days) from the date signed, unless otherwise noted.

____________________ Signature of Patient or Patient's Legal Representative

____________________ Date

____________________ Printed Name

____________________ Relationship of Patient Legal Representative