Juan L. Sotomayor, MD, PC
ALLERGY & ASTHMA
Diagnostic Office

5229 Witz Drive · North Syracuse, New York 13212 · (315) 701-9500 · FAX (315) 701-9555
www.allergyaway.com
Juan Sotomayor, MD · Jill Agne, FNP · Summer Goetz, FNP · Katie Klee, FNP · Anna Salvagno, FNP

Authorization to Request Medical Records

Patient's name_____DOB_____

Address_____

City_____State_____Zip code_____

Dear Dr. _____

Address_____

_____

Please transfer medical records for the above named patient to:

Fax 315-701-9555
Allergy and Asthma Diagnostic Office
5229 Witz Drive
North Syracuse, NY 13212

Please specify the information you authorize us to release (check all that apply):

- ☐ Entire medical record
- ☐ All medical records from dates: _____ to _____
- ☐ Other (please specify): _____

Authorization

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

_____ _____
Name of Individual Relationship to Patient

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.
_____I understand that I may inspect or request a copy of information that is used or disclosed under this authorization.
_____This Authorization of Release will expire in 60 days from the date signed. I understand that I may revoke this authorization at any time; however, the information sent before this will not be affected by the revocation.

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to Patient

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