Allergy & Asthma

DIAGNOSTIC OFFICE

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PATIENT REQUEST FOR RELEASE OF HEALTH CARE RECORDS FROM ANOTHER PROVIDER OF SERVICE.

PATIENT NAME: _____
Address: _____

Birthdate: _____ Last 4 of SS#: _____

Dear Dr. _____

Address: _____

_____

Phone # _____ Fax #_____

Please transfer medical records for the above named patient to:

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

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: _____

_____

Authorization to Discuss Health Information:

By initialing here _____ (Initial), I authorize _____ (Name of Individual health care provider/Physician's 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 my health information released may no longer be protected by HIPAA privacy regulations protected under the federal privacy rules.

_____ 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 make revoke this authorization at any time; however the information sent before this will not be affected by the revocation.

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____ _____
Printed Name Relationship of Patient Legal Representative