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Diagnostic Office

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# Patient Authorization for Release of Records

**Patient Information**
Patient's name_____DOB_____
Address_____
City_____State_____Zip code_____
Phone number_____

The purpose of this release of information is for:

- ☐ Transfer of records to another provider for *Transfer of Care* for the following reason:_____
- ☐ Copy of records to another provider for treatment or for *Continuity of Care*
- ☐ Attorney
- ☐ Insurance Claims Information
- ☐ Other (please describe reason): _____

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

**Person/Organization Authorized to Receive Information***

Name _____
Address_____
City_____State_____Zip code_____
Phone Number_____ Fax_____
*Records will only be faxed to another provider office and can take up to 14 days to process

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 Representative Date

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