Allergy & Asthma
DIAGNOSTIC OFFICE

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MEDICAL RECORDS RELEASE & AUTHORIZATION FORM

1. PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

2. PURPOSE OF REQUEST (Select all that apply)

☐ Transfer of Care ☐ Continuity of Care (treatment) ☐ Personal Request ☐ Legal Request

☐ Other (please specify): _____

3. DIRECTION OF RECORDS

☐ Release records **FROM** Allergy & Asthma Diagnostic Office to another provider or individual

☐ Request records **FROM** another provider and send them **TO** Allergy & Asthma Diagnostic Office

Requesting From (Provider/Practice Name, Address, and/or Fax, if known): _____

_____

4. RECORDS TO BE RELEASED / REQUESTED

☐ Entire Medical Record (including histories, office notes, test results, radiology studies, consults, billing records, insurance information, and records from other health care providers)

☐ Specific Dates of Service: From _____ To _____

☐ Other (please specify): _____

5. PATIENT AUTHORIZATION

I authorize Allergy & Asthma Diagnostic Office to release and/or obtain the medical records specified above.
I understand that this information may be used for treatment, payment, and health care operations and is protected under HIPAA privacy regulations.

- I understand I may revoke this authorization at any time in writing, except for information already released.
- This authorization will expire 1 year (365 days) from the date signed, unless I specify an earlier date: _____.

You may be charged up to $0.75 per page for records. There may also be additional mailing fees.

_____ _____
Signature of Patient or Legal Representative Date

Printed Name: _____ Relationship to Patient (if not patient): _____

6. AUTHORIZATION TO DISCUSS INFORMATION (Adults 18+ Only – Optional)

If you are 18 years of age or older and would like to authorize another person to contact our office and discuss your medical information (e.g., appointments, test results, treatment, or billing), please complete below.

Authorized Individual Name: _____

Relationship to Patient: _____ Phone: _____

Note: *This authorization allows us to speak with the individual listed above about your care.*
It does not authorize the release of your medical records or allow the individual to make medical decisions on your behalf.

Patient Signature: _____ Date: _____