**Allergy, Asthma & Immunology Center (AAIC),** PLLC.

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**Top of Form**

**Bottom of Form**

**AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS FROM AAIC**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Daytime phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Allergy, Asthma & Immunology Center, PLLC to release my medical information and/or individually identifiable health information to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as may be required or permitted under federal or state law. I further authorize physician to release such information to physicians, hospital, or healthcare providers needing such information to treat me or to review my treatment. I understand that the specific information to be released may include, but is not limited to, history diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease. I also understand that this authorization may be revoked by me by a written and dated notice, except to the extent that disclosure of information has been made prior or receipt of such revocation.

I authorize the use of a copy of this release and consent in place of the original.

Information Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of legally authorized representative if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If representative, specify relationship of individual: Parent of Minor or Guardian or Other\_\_\_\_\_\_\_\_\_\_\_\_

Effective Time Period:

This authorization is valid until the permission is withdrawn or 1 year from date of signature.

For office use only:

Allergy, Asthma & Immunology Center

Date received: \_\_/\_\_\_/\_\_\_\_\_\_ Date processed: \_\_/\_\_\_/\_\_\_\_\_\_ Office personnel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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