Cranberry Allergy Asthma and Clinical Immunology

119 VIP Drive, STE 204 Wexford, PA 15090
Phone: (724) 935-1111 Fax: (724) 704-7832

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

I authorize ____ to disclose/release the information as described below from the record of:

Patient Name: ____

Address: ____

____

Phone: _______________________________ Date of Birth:_____/_____/_____

(check all that are applicable):

□ All records	□ Laboratory records	□ X-ray/Radiology records
□ Billing records	□ History and Physical	□ Discharge Summary
□ Medication Lists	□ Pathology Records	□ Physician Progress Notes
□ Consult Reports	□ Pulmonary Function Testing	□ **Serum IgE/ Immunocap /Allergy tests**

□ Other (specifically)____

The records requested should include services provided in the following range of dates: _________________

Note: HIV and Mental Health information contained in the parts of the records indicated above will be released through this authorization unless otherwise specified here: **Do not release:** □ **HIV** □ **Mental Health** □ **Drug & Alcohol**

Please send the records listed above to:

Cranberry Allergy Asthma and Clinical Immunology
119 VIP Drive, Suite 204
Wexford, PA 15090
Phone: (724)935-1111
Fax: (724) 704-7832

The information may be used/disclosed for each of the following purposes:

□ At my request (only the patient can check this box)	□ For my health care/ continued medical care
□ For payment/insurance	□ For employment purposes
□ For legal purposes	□ Other: ________________________________

This authorization shall expire no later than: ___ /___ /___ and may not be valid for greater than one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity I authorized above to release the information. My decision to revoke the Authorization does not apply to any release of my records that may have taken place prior to the date of my revocation of the Authorization. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary (ie. I may refuse to sign it) and that I am not required to sign this form in order to receive treatment.

____	______________________________________
Signature of patient (or patient's personal representative)	Date
____	______________________________________
Printed name of patient representative	Representative's authority to sign for patient, (i.e parent, guardian, power of attorney for healthcare, executor)