MEDICAL RECORD RELEASE OF INFORMATION

Print Patient Name: _____SS#: _____

Date of Birth:_____ Telephone: _____

Email: _____Address: _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below.
The following individual or organization is authorized to make the disclosure:
Clinic Name: **Asthma & Allergy Associates PA**
Dr. Ron Weiner & Dr. Warren Frick
City, State, Zip Code: **4601 W 6th St, Ste B Lawrence, KS 66049**

The type and amount of information to be used or disclosed in as follows:

- ☐ Entire Medical Record
- ☐ 2 years - entire medical record
- ☐ Specific information _____Date Range_____to_____

RESTRICTIONS: Only medical records that have originated through this health care facility unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization. A photocopy charge will be incurred for "ALL" requests unless mailed directly to another doctor.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HN). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following:

Release to:_____
Street address: _____ Phone #: _____
City, State, Zip Code:_____ Fax #: _____

For the purpose of: ___Transfer of Medical Care

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire I year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making the disclosure.

I have read the above foregoing Authorization of Release of Information (ROI) and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

Date Signature of Patient, guardian or authorized representative

There is a fee for medical records unless sent per your request to another doctor.