ALLERGY & ASTHMA CENTER

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM.

I, ___________________________, hereby voluntarily authorize the disclosure of information from my health record. I understand it could take up to 10 business days for the information to be released.

Patient Information:

Patient Name: ____ AAC#: _____________________
Address: ____ Date of Birth: _______________

Information Requested:

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Purpose of Release:

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The Information Is To Be Provided To:

Name of Person/Organization/Facility: ____

Address: ____

Phone Number: ________________________

____ ____________________________________
Patient's signature or Patient's Representative Date

____ ____________________________________
Printed name of Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS. THERE WILL BE A CHARGE FOR YOUR RECORDS.