ALLERGY & ASTHMA CENTER

Stephen D. Lockey, III, M.D.*
Robin Rochow, PA-C
Kayla Wirth, PA-C

***Diplomates of the American Board of Allergy and Immunology**

2445 Marietta Avenue
Lancaster, Pennsylvania 17601

Fax: (717) 393-8540
Telephone (717) 393-1365
www.allergydoctors.com

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:

_____
_____
_____

Purpose of Release:

_____
_____
_____

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.

HIPPA Authorization For Release Of Medical Records