Patient's Name:______________________________________ Mail to: [ ]
Street Address:______________________________________
City:____
State:____
Zip code:____ Mail to: Patient address listed on left [ ]
Date of birth:_______________________________________ I will pick my records up [ ]

I, ____, hereby request that my complete medical records (including History & Physical, office visits, pulmonary function tests, lab results), immunotherapy prescriptions, vials, and shot records be released

From:____

To: ____

to disclose my protected health information.

The purpose or need for disclosure: (Check applicable categories)

[ ] Further Medical Care

[ ] Other:____

This authorization will remain in effect until ______________________at which this authorization to disclose this protected health information will expire.

I authorize release of my medical records in accordance with the specification listed above. I understand that I have the right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

Revocation. I have the right to revoke this authorization, in writing, at any time before it ends.
Re-release. I understand that if the person(s) and/or organization(s) authorized by this form to receive my medical information is a not health care provider or others who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release my medical information without my prior permission.
Right to Inspect. I have the right to inspect or copy the medical information whose disclosure I am authorizing, with certain exceptions provided under state and federal law.

Signatures. I understand that generally if I am 18 years of age or older, I am the only person who is permitted to sign a form to authorize the disclosure of my medical information. If I am under the age of 18, my parent or guardian must sign this form.

Signature of Patient____ **Date**________________________

Signature of Parent/Legal Guardian ____ ______________________
(Please state relationship to patient and authority to do so) Relationship

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.