Birmingham Allergy Asthma Specialists, PC

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Request for Medical Records

Patient Name:________________________________ Street address:________________________________

Date of Birth:________________________________ City:________________________________

Phone:________________________________

I hereby request my medical records be released

From: ____

Phone:______________________ Fax: ______________________

To: Birmingham Allergy & Asthma Specialists, PC

- □ Fax to: 205-879-2995
- □ E-mail to: receptionist@birminghamallergy.com
- □ Mail to: 3125 Independence Drive, Suite 100, Homewood, AL 35209
- □ I will pick my records up in the office

Please send the following information:

□ Dates of service: From ______________________ to ______________________

□ Specific records: □ Laboratory results □ Allergy testing results □ Imaging studies □ Biopsy results □ Procedure reports □ H&P □ Office Notes □ Immunotherapy prescription

□ Entire record

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 to the old practice 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 are not health care providers or other people 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 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. I will contact Susan Wells, privacy officer at Birmingham Allergy & Asthma Specialists, PC at 3125 Independence Drive, Suite 100, Homewood, Alabama 35209, if I would like to review my records.

Signatures: I understand that generally if I am 18 years 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: ________________________ 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 specific written consent of the patient or legal representative involved.