ALLERGY & CLINICAL IMMUNOLOGY MEDICAL GROUP
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Please release the following records to _____

Fax number: _____

Address: _____

☐ Skin Test Results ☐ Immunotherapy Record ☐ Progress Notes (last year only)

☐ Laboratory Results ☐ Complete Medical Records, including those from other doctors

☐ Other _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named above to disclose my health information during the term of this Authorization to the recipient that I have identified above. This Authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Revocation: I understand that the Authorization will remain in effect until the term of the Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular off ice address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Print Name of Responsible Party (if other than Patient) Relationship to Patient

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For **printed copies** of records please include a check for $6.50 payable to: **Allergy & Clinical Immunology** or Credit Card information:

Card Number _____

Expiration Date _____ CVV _____ Zip Code _____