Clear Allergy

3831 Hughes Ave Ste 600A
Culver City, CA 90232

Office: (424) 603-4544
Fax: (424) 603-4546

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____

I request access as the: ☐ Patient ☐ Parent/Guardian ☐ Medical Power of Attorney: (Proof of legal documentation is required)

Name of Patient_____Date of Birth_____

Street Address _____ Contact Phone_____

City_____ State_____ Zip Code_____

REQUESTING RECORDS FROM:

_____

Name of Medical Office/Provider

Telephone:_____ Fax:_____

SEND RECORDS TO:

_____

Name of Medical Office/Provider

Telephone:_____ Fax:_____

California law (AB610) allows the healthcare provider a 15-day turnaround time from the date a request is received in order to process a patient's request for copies of their medical records. Clear Allergy turn-around time is about 10 business days.

☐ All General Medical Information (from _____to _____). General medical records may include information of diagnosis and / or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This may include information and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. Information regarding specific injury or treatment (from_____ to _____)

☐ Other (Specify): _____

Duration: This authorization will expire 12 months from the date signed. **Right to Copy:** I have a right to receive a copy of the Authorization after I sign it.
Revocation Process: I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Clear Allergy.
Re-Disclosure Statement: I understand that once Clear Allergy discloses my health information to the recipient, Clear Allergy cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization of Applicable law governing the use and disclosure of my health information.
I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Clear Allergy to use or disclose my health information in the manner described above.

_____

Date **Signature of Patient or Representative Indicate Relationship (if not signed by patient)**