Diplomate American Board of
Allergy and Clinical Immunology

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Release of Medical Records

Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: _____ **DOB:** _____

I authorize records from: To be released to:

_____ Name: _____
Address: _____
City: _____

This authorization shall become effective immediately and shall remain in effect for 1 year from the date of signature unless a different date is specified here. (_____)

- I have the right to revoke this authorization at any time.
- I understand the recipient of the patient's medical records may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless is specifically required or permitted by law.
- I understand that I may review or retrieve a copy of my (child's) medical records that will be disclosed to the recipient above.

Check the box of the medical records to be released. If there is a specific date of service, please indication the date.

- ☐ History & Physical _____
- ☐ Allergy Skin Testing _____
- ☐ Spirometry/PFT _____
- ☐ Imaging/Lab Results _____
- ☐ Antigen/Allergy Shot Record _____

Specify any other records _____

Signature: Patient/Guardian _____ **Date:** _____
Personal Representative _____ **Date:** _____

To be completed by office staff: Records were sent on: Date: _____

- ☐ USPS (Mail)
- ☐ Secure Fax
- ☐ Patient (Parent) will pick up records from AIAMG