

Allergy & Asthma of Southern Indiana, P.C.

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BOARD CERTIFIED

Pediatrics

Internal Medicine

Pediatric & Adult Allergy and Immunology

RELEASE OF MEDICAL RECORDS

I AUTHORIZE ALLERGY & ASTHMA OF SOUTHERN INDIANA, P.C. TO RELEASE MY MEDICAL RECORDS TO:

NAME: _____

ADDRESS: _____

PATIENT NAME: _____ DOB: _____

ADDRESS: _____

PLEASE SEND:

____ COMPLETE MEDICAL RECORDS

____ SKIN TESTING RESULTS

____ LAB WORK

____ RADIOLOGY REPORTS

____ PULMONARY FUNCTION RESULTS

____ OTHER - _____

USE OF DISCLOSURE: _____

SPECIAL NOTES: _____

I understand that I have the right to revoke this authorization in writing at any time, but this would not affect any disclosures that were permitted/made while this authorization was in effect. I further understand that my Protected Health Information that is used or disclosed under this authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

DATE: _____ WITNESS: _____