ALLERGY, ASTHMA & SINUS CENTER P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Telephone # _____

I request and authorize Allergy, Asthma & Sinus Center to release the medical records of the patient named above to:

Name: _____

Address: _____

City,State,Zip: _____

Telephone # _____ Fax #_____

Please check any required records below:

____Office Visits ____Skin Test Results ____PFT Results ____Laboratory Records

____Radiology/X-Ray Records - Other_____

There is a base fee of $10.00 for pages 1-15. Pages 16 and more, there is an additional $0.25 charge per page. Postage to be determined. All must be paid when picked up or faxed.

_____ _____
Signature of patient or patient's authorized representative Date

_____
Printed name of patient's authorized representative

I understand that after the disclosure of my records, it may no longer be protected by Federal Privacy laws. This release does not authorize redisclosure of medical information beyond the limits of this consent. AASC is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization from me, the patient. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to AASC. I agree that any release made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.