Allergy, Asthma & Sinus Center, P.A.

Gurdev S. Judge, MD **Stephen Begley, P.A.-C**

Board Certified in Allergy and Immunology - Pediatrics and Adult

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MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize **Allergy, Asthma and Sinus Center, P.A.** to release my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

To:_____

Address:_____

City:_____ State: _____ Zip: _____

Specific information to be released:

☐ History and Physical ☐ Staff /Progress Notes ☐ Allergy Test Results ☐ Allergy Vaccine Contents

☐ Lab Test Results ☐ Other_____

☐ All dates of treatment / ☐ Only these dates of treatment (specify):_____

Please indicate the purpose or reason for this request:

☐ Consulting a new physician in a different specialty.

☐ Moving out of the area.

☐ Transferring medical care to another allergist.

☐ Copy for my personal record.

☐ Other: _____

How will you describe services provided at **Allergy, Asthma and Sinus Center P.A.**

☐ Excellent ☐ Satisfactory ☐ Not Satisfactory

I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that **Allergy, Asthma and Sinus Center, P.A.** has taken action in reliance on it. A revocation is effective upon receipt of a written request to revoke authorization.

Signed by:_____ _____

(Signature of Patient or Legal Guardian) (Relationship to Patient)

_____ _____ _____

(Print Name of Patient or Legal Guardian) (Patient's Date of Birth) (Today's Date)

This authorization will expire one year from date of authorization or: _____.

{Expiration Date or Defined Event}