

Request for Release of Medical Records

I authorize the disclosure of health information for the individual named below:

Patient Legal Name _____ Date of Birth _____

Address _____ Phone Number _____

Description of information that may be used/disclosed:

- | | |
|-----------------------------------------------------------|-------------------------------------------------------------------------------------|
| <input type="checkbox"/> Medication list | <input type="checkbox"/> Actual Skin Test Results (copy of testing sheet preferred) |
| <input type="checkbox"/> Problem list | <input type="checkbox"/> Actual Recipe of Treatment Extract & Injection Record |
| <input type="checkbox"/> Evaluation and Treatment Reports | <input type="checkbox"/> Laboratory Results, from date _____ to date _____ |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> X-ray Reports, from date _____ to date _____ |
| <input type="checkbox"/> Most Recent 3 years | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Entire Medical Record | |

This information may be disclosed to and used by the following individual or organization:

Records are requested from (Requesting Physician) _____

Address _____
Street City State Zip Code

Fax Number _____ Phone Number _____

To be disclosed to and used by (Name) _____

Address _____
Street City State Zip Code

Fax Number _____ Phone Number _____

- I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever comes first.
- I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
- I understand authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on the signing of an authorization, except as otherwise permitted by law.
- I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information used/disclosed carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Our Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our notice of Privacy Practices before you sign this consent, and we encourage you to read in full.

Patient/Guardian Signature _____ Date _____