MAIN LINE ALLERGY, LLP

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AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

RELEASE MEDICAL RECORDS TO:

Facility/Name: _____

Address: _____ City/State/ZIP: _____

Phone #: _____ Fax #: _____

If you have an upcoming appointment with a physician requesting these records, what is the date of this appointment? (if applicable): _____

RECORDS REQUESTED: please select the following

Skin Testing _____ Labs _____ Office Notes _____ Allergy Shot History _____ Other _____

☐ Regarding a vaccine formula, I understand and agree that a signed consent is required from both the patient and the requesting physician.

PURPOSE OF DISCLOSURE

☐ Information provided to primary care physician/other specialist ☐ Personal Copy

☐ Information provided to another allergist/pulmonologist ☐ Other _____

AUTHORIZATION

I may revoke this Authorization at any time by notifying Main Line Allergy in writing. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed. This Authorization expires 90 days from the signature date.

Patient/Guardian/Representative Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

TURNAROUND FOR ALL REQUESTS IS 3–10 BUSINESS DAYS