MAIN LINE ALLERGY, LLP

www.mainlineallergy.com

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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? _____

FEES: I understand / agree that fees may be associated with this request in compliance with State and Federal copying laws. (Fees apply to personal copies / copies for third parties.)

RECORDS REQUESTED: Skin Testing _____ **Labs** ____ **Office Notes** _____ **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 *(please specify)*:

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

☐ **Information provided to another allergist/pulmonologist** ☐ **Other** _____

AUTHORIZATION:

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

Patient/Guardian/ Representative Signature: _____ **Date:** _____

Patient/Guardian/ Representative Printed Name: _____ **Relationship to Patient:** _____

TURNAROUND FOR ALL REQUESTS IS 10 – 14 BUSINESS DAYS UNLESS WE ARE CONTACTED BY A PHYSICIANS OFFICE

2019; kpc