

ALLERGY AND ASTHMA CARE, P.A.

12000 ELM CREEK BLVD. # 200
MAPLE GROVE, MN 55369
TEL (763) 420-1010
FAX (763) 420-3710

Name:
DOB:
(Label)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:	Name		Date of Birth
	Address		Day Phone #
	City	State	Zip
	Social Security Number		

Provider:	WHO HAS INFORMATION YOU WOULD LIKE RELEASED?		
	Name		Phone #
	Address		
	City	State	Zip

Requestor:	TO WHOM SHOULD THE INFORMATION BE SENT?		
	Name		Fax #
	Address		
	City	State	Zip
	E-mail		

Information To be Disclosed:	MEDICAL RECORD RELEASE	
	Records Concerning: _____ (Specific Diagnosis or Treatment and Specific Dates of Service)	
	<input type="checkbox"/> Clinic visit notes	<input type="checkbox"/> Allergy Testing
	<input type="checkbox"/> Consultation/Follow-up Reports	<input type="checkbox"/> Immunotherapy Formulas
	<input type="checkbox"/> X-Ray & Imaging Reports (Chest, Sinus)	<input type="checkbox"/> Immunotherapy Schedules
	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Other (Specify) _____
	<input type="checkbox"/> EKG Reports	_____

Revocation:	I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when the provider receives my notice in writing.
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Authorization:	I authorize the above provider to release the information marked above to the requestor.	
	Patient Signature	Date
	If other than patient, please state the relationship and reason patient cannot sign:	

