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Adult/Pediatric Allergy & Immunology

Patient Request for Release of Healthcare Information

Date: _____

Patient Name _____ Date of Birth _____Phone_____

Address _____ City _____ State _____ Zip_____

I request that my protected health information (PHI) is ☐ RELEASED TO: ☐ OBTAINED FROM:

Recipient_____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

I authorize the following PHI to be released from my medical record(s):

□ Lab Results □ CT Scans/Chest X-Rays
□ Office Note □ Allergy Test results
□ All of the above □ Biopsy Other: _____

Date range _____ to _____ **OR** specific date(s) of service: _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

Purpose for requesting information: □Personal □Legal □Insurance □Transfer or continuation of care
Disclosure format (paper is default if not marked) □ Paper-US mail □ Fax □CD/flash drive
By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition_____ *or* will expire _____ from the date signed.
  insert time frame
- I have a right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at 840 US Highway One, Suite 235, North Palm Beach, FL 33408. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

_____ _____ _____
Patient or Authorized Representative Signature Print Name Date

_____
Relationship to patient

Office use only:	*Account#*	*MR#*	*Completed by/date*

Rev. 10/2016

Fax: 561-626-8622

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ATTENTION: If you need language assistance services, the office will provide free of charge. Please call 561-626-2006.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 561-626-2006