Attention: Medical Records Request received by: _____
Date: _____

ALLERGY & ASTHMA SPECIALISTS, P.A.

Authorization for Release of Protected Health Information

Patient Information

_____

Name (Last, First, MI) *Birthdate*

_____

Street Address *City/State/Zip*

_____

Home Phone # *Work Phone #* *Cell Phone #*

RELEASE RECORDS TO: ☐ **FROM:** ☐

Allergy & Asthma Specialists, P.A.
825 Nicollet Mall, Suite 1149
Minneapolis, MN 55402

Send to the attention of:

_____

Phone #: (612)-338-3333 Fax #: (612)349-3838

RELEASE RECORDS TO: ☐ **FROM:** ☐

_____

Name (Clinic, Physician)

_____

Street Address

_____

City/State/Zip

Phone #: _____ *Fax #:* _____

WHICH RECORDS ARE TO BE RELEASED: (check all applicable categories):

☐ Entire Record ☐ Office Visit Notes ☐ Pulmonary Function Test ☐ Lab Reports
☐ Skin Testing ☐ X-ray/CT Scan Reports ☐ Hospital Records
☐ Immunology ☐ Serum Formula ☐ Shot History

Allergy & Asthma Specialists, P.A. will release serum formula and shot history to other allergy clinics. If the medical records are sent to another care giver, i.e. primary care, the serum formula and shot history will be released upon request.

☐ Other: _____

*** All records pertaining to a sensitive nature, such as STD testing and/or psychiatric/mental health will be released unless indicated here: ☐ **Do not release records of a sensitive nature as described above.**

Purpose For Release: **Date Needed:** _____

☐ Further Medical Treatment ☐ Application for Insurance ☐ Change of Clinics
☐ Legal/Attorney Request ☐ Insurance Claim or Payment ☐ Research

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand I may revoke this authorization at any time providing notification in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand there may be a charge incurred for copies of medical records pursuant to MN Statute 144.335 and Rule 164.524.
- I understand when Allergy & Asthma Specialists, PA discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality or prevent redisclosure, and the information may no longer be protected by federal privacy rules.
- I understand by signing this authorization, I agree to allow Allergy & Asthma Specialists, PA and all their staff members to disclose the following protected health information to the above stated person(s) or entity.
- I understand by signing this authorization, I agree to all its contents and release Allergy & Asthma Specialists, PA from any and all liability resulting from re-disclosure.
- I further understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form.

_____ _____

SIGNATURE *(Patient / Legal Representative)* / DATE
(age 18 or over must sign for release of their records)

AUTHORITY *to act on behalf of Patient*
(Attach document)