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SPECIALIZING IN PEDIATRIC AND ADULT ALLERGY, ASTHMA & IMMUNOLOGY

MEDICAL RECORDS RELEASE FORM

Patient Name: ____ DOB: ___________

Previous Name: ____________________________ Cell phone number:_________________

By signing this form, I hereby authorize Dr. Sullivan to release or request confidential health information about me.

Specifically, **I give permission to** __________________________________ **to fax or mail a copy of my medical records**, or a summary/narrative of my protected health information, to the physician/person/facility/entity listed below.

This request and authorization applies to:

( ) Progress Notes
( ) Allergy Testing Results
( ) Spirometry Results
( ) Laboratory Results
( ) X-ray reports
( ) Immunotherapy Records
( ) Other _______________

This information will be disclosed for the following purposes: _________________________

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Please release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: ____

Address: ____

City: State: Zip Code: ____

Phone Number: _______________________ Fax Number: ___________________________

Signature of Patient/Representative: ______________________________ Date: ________

Relationship if not patient signature: Parent: ____, Legal guardian ____, other __________

This request may take up to 30 days to complete.

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