



Ray S. Davis, M.D., FAAAAI
 Jeffrey M. Wright, M.D., FAAAAI
 Lisa V. Suffian, M.D., FAAAAI

456 N. New Ballas Road, Suite 129
 St. Louis, Missouri 63141
 (314) 569-1881 / FAX: (314) 569-3277

RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that:

Release my records to:

Allergy Consultants
456 N. New Ballas Road
Suite 129
St. Louis, MO 63141
FAX: 314-569-3277

Fax ____ Mail ____

I specifically authorize you to send the following protected health information and/or medical records, if such information and/or records exist:

Please send the entire medical record (all information) to Allergy Consultants.

Office chart; notes

Allergen Extract formula

Laboratory reports

Skin test results

CT/Xray reports

Other: _____

1. I understand that if the person(s) or entity(ies) that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release Allergy Consultants, its employees, and my physicians from all liability arising from this further disclosure of my health information.
2. I understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.
3. I understand that I may inspect or request copies of any information disclosed by this Authorization. It is my understanding that this Authorization will expire in 90 days from the date signed below. I understand that I may revoke this Authorization by notifying, in writing, Allergy Consultant's Privacy Officer, knowing that previously disclosed information would not be subject to my revocation request.
4. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits.

 Patient Name (please print)

 Date of Birth

 Signature; Patient or Legal Representative

 Date

 Signature of Witness

 Date