Adult and Pediatric Allergy

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RECORDS RELEASE AUTHORIZATION

I hereby authorize and request that:

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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**