Allergy Institute, P.C.

Phone: 515-223-8622
Fax: 515-223-5324
Email: care@aipcia.com

Authorization to <u>Release</u> Protected Health Information

This request will be honored within 7-10 business days. There may be a fee depending on the size of your medical records. Prepayment is required before your medical records will be sent.

Patient's name

_____

(Last) (First) (Middle)

Address

_____

(Street) (City) (State) (Zip)

Phone _____ Birthdate _____ SS_____-_____-_____

I authorize Allergy Institute, P.C. to release medical information from my medical records and send it to:

Name of Physician or Clinic

_____

Address _____City _____State_____ Zip_____

Phone No: _____ Fax No:_____

I authorize you to release by **mail/fax/pick-up** my entire record to the physician named above **<u>EXCEPT</u>** for the following limitations, if any:

No limitations _____

Any medical record from other physicians or providers _____

Only information related to the following _____

1. HIV / AIDS_____
2. Mental Health_____
3. Substance Abuse _____

This authorization will automatically expire one year from the date signed. I understand that i may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

_____

Signature of Patient/Guardian

_____

Relationship to Patient

_____

Date

Allergy Institute, P.C.

Phone: 515-223-8622
Fax: 515-223-5324
Email: care@aipcia.com

Authorization to <u>Receive</u> Protected Health Information

Please fax records to 515-223-5324

Patient's name

_____

(Last) (First) (Middle)

Address

_____

(Street) (City) (State) (Zip)

Phone _____ Birthdate _____

I authorize the below stated clinic to release my medical records to the Allergy Institute, P.C.

Name of Physician or Clinic to Release Records: _____

Address _____City _____State_____ Zip_____

Phone No: _____ Fax No:_____

I authorize the above clinic to to send my medical records via fax or mail. I authorize the release of my entire record to the Allergy Institute **<u>EXCEPT</u>** for the following limitations, if any:

No limitations _____

Any medical record from other physicians or providers _____

Only information related to the following _____

1. HIV / AIDS_____
2. Mental Health_____
3. Substance Abuse _____

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

_____

Signature of Patient/Guardian

_____

Relationship to Patient

_____

Date