Allergy Institute, P.C.

Phone: 515-223-8622

Fax: 515-223-5324

Email: staff@allergyinstitutepc.com

Authorization to Release 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.

Patients 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 record and send it to:

Name of Physician or Clinic _____

Address _____

City/State/Zip Code _____

Phone # _____ **Fax #**_____

I authorize you to release by **mail/fax/pick-up** my entire record to the physician named above **EXCEPT** 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