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 Aller	gy Institute, P.C. to rel	ease medical informat	ion from my me	dical records	and send it to:
Name of Physici	an or Clinic				
Address		City		State	Zip
		Fax	No:		
Phone No:		I u			
I authorize you to	o release by mail/fax/pi			n named abov	e <u>EXCEPT</u> for the following
I authorize you to	o release by mail/fax/pi		l to the physicia	n named abov	e <u>EXCEPT</u> for the following
I authorize you to	o release by mail/fax/pi 7:	ck-up my entire record	l to the physicia		e <u>EXCEPT</u> for the following
I authorize you to	o release by mail/fax/pi r: Any medical rec	ck-up my entire record No limitatior cord from other physic	l to the physicia s ans or providers	3	e <u>EXCEPT</u> for the following
I authorize you to	o release by mail/fax/pi r: Any medical rec	ck-up my entire record No limitation cord from other physic ly information related	l to the physicia s ans or providers	3	e <u>EXCEPT</u> for the following
	o release by mail/fax/pi r: Any medical rec	ck-up my entire record No limitation cord from other physic ly information related t 1. HIV / 2	l to the physicians ans ans or providers to the following	3	e <u>EXCEPT</u> for the following

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

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)	(I	First)	(Middle)
Address				
	(Street)	(City)	(State)	(Zip)
Phone		Birthdate		
[authorize the b	elow stated clinic to rel	ease my medical records to	the Allergy Institute, P.O	С.
Name of Physici	an or Clinic to Releas	e Records:		
Address		City	State	Zip
Phone No:		Fax No:		
		y medical records via fax or llowing limitations if any:	mail. I authorize the rele	ease of my entire recor
		llowing limitations, if any:		ease of my entire recor
	ute <u>EXCEPT</u> for the fo	ollowing limitations, if any: No limitations		ease of my entire recor
	ute <u>EXCEPT</u> for the fo	ollowing limitations, if any: No limitations cord from other physicians c	or providers	ease of my entire recor
	ute <u>EXCEPT</u> for the fo	ollowing limitations, if any: No limitations	or providers following	ease of my entire recor
	ute <u>EXCEPT</u> for the fo	ollowing limitations, if any: No limitations cord from other physicians of ly information related to the	or providers following	ease of my entire recor

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Signature of Patient/Guardian

Relationship to Patient