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 Board Certified Allergy and Immunology*
 "Treating Children & Adults since 1983"

AUTHORIZATION TO OBTAIN OR RELEASE PROTECTED HEALTH INFORMATION

I, _____ HEREBY AUTHORIZE Allergy Asthma Specialists, PA to:
 PATIENT'S NAME

OBTAIN copies of my medical records from:

Facility/Physician: _____
 Address: _____
 Street City State Zip
 PHONE NUMBER: _____ FAX NUMBER: _____

I, _____ HEREBY AUTHORIZE Allergy Asthma Specialists, PA to:
 PATIENT'S NAME

RELEASE my medical records to:

Facility/Physician: _____
 Address: _____
 Street City State Zip
 PHONE NUMBER: _____ FAX NUMBER: _____

Place a mark by each item to be released: From: _____ to _____

- | | | |
|--------------------------|--|--|
| _____ Record Summary | _____ Radiology results X-ray, CT, MRI | _____ Hospital Summary |
| _____ Skin test results | _____ Lab results _____ | _____ Concentration & List |
| _____ Pulmonary Function | _____ Pathology/skin biopsy reports | _____ of each Antigen/Mixes in extract |

This release includes Mental Health, Drug/Alcohol, HIV/AIDS results and treatment therein under the Abstract Medical Record status. This release is for continued treatment and/or _____ other reasons.

PATIENT'S NAME: _____ DOB: _____
 FULL LEGAL NAME (FIRST MIDDLE LAST)

PATIENT'S SOCIAL SECURITY NUMBER: _____

SIGNATURE: _____ DATE: _____
 PATIENT OR GUARDIAN

ADDRESS: _____
 Street City State Zip

PHONE NUMBER: (_____) _____

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV&/or Aids information is confidentially protected by Federal and State Law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I understand that I may select the information from the list above to be released by marking the appropriate information to be released. Furthermore, I understand that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I understand that this authorization will expire one year from the date listed.

SEND or FAX RECORDS TO THE ADDRESS THAT IS CHECKED

- | | | |
|--|--------------|-------------------------|
| () 661 E ALTAMONTE DR Ste 315 ALTAMONTE SPRINGS, FL 32701 | 407-339-3002 | <u>FAX 321-397-5085</u> |
| () 7758 WALLACE RD Ste J ORLANDO, FL 32819 | 407-351-4328 | <u>FAX 407-351-1755</u> |
| () 1142 KELTON AVE, OCOEE, FL 34761 | 407-219-3620 | <u>FAX 407-347-7586</u> |
| () 3111 CITRUS TOWER BLVD. SUITE A CLERMONT, FL 34711 | 352-243-6767 | <u>FAX 352-243-2255</u> |
| () 7780 LAKE UNDERHILL RD STE 110, ORLANDO, FL 32822 | 407-608-7871 | <u>FAX 407-608-7872</u> |