www.nationalallergyandasthma.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:_____________________________________ Social Security Number:______________________

DOB:_________________ Street Address:_______________________________ City:_______________________

State:_______________ Zip Code:_______________ Telephone:_________________________

☐ I authorize National Allergy and Asthma to **obtain** information from:

____ ___________________________________
Physician/Practice Name Physician/Practice Telephone Number

____
Street Address City State Zip

Please forward all requested information to: Fax: 843-797-8372

☐ I authorize National Allergy and Asthma to **disclose/release** information to:

____ ___________________________________
Physician/Practice Name Physician/Practice Telephone Number

____
Street Address City State Zip

Information Requested: ☐ All Records ☐ Specific Date(s) of Service: __________________

All records will be sent via fax: 843-797-8372

**Patients will be charged for a personal copy of their records. Fees charged are in accordance with Physicians Patients Medical Records Act SC Code ANN-44-115-90
** I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to National Allergy & Asthma Centers. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to obtain such information. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _______________. If I fail to specify an expiration date, event or condition, this authorization will expire twelve months from the date of my signature below.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the health information department or privacy officer.

____ ___________________________
Patient/Parent or Guardian of Patient Signature Date