Allergy & Asthma Specialists, P.S.C.

Lee S. Clore, Jr., MD - Board Certified Allergy/Immunology

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ Date of Birth:_____

Phone Number: _____ Social Security #:_____

Address:_____ City/State/Zip:_____

INFORMATION TO BE RELEASED FROM:

Facility Name:_____
Address:_____
City/State/Zip:_____
Phone Number: _____

INFORMATION TO BE RELEASED TO:

Facility Name:_____
Address:_____
City/State/Zip:_____
Phone Number: _____

Information to be released:

- ☐ The most recent 2 years of pertinent information (chart notes, labs, skin tests/results, breathing tests)
- ☐ All medical records
- ☐ Other: _____

Purpose for which disclosure is being made:

- ☐ Personal Use
- ☐ Legal investigation
- ☐ Other: _____
- ☐ Sharing with other health care providers
- ☐ Transferring my care to a new health care provider

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Jean Owen, Practice Administrator, Allergy & Asthma Specialists, PSC, 3604 Wathens Crossing, Owensboro, KY 42301. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that the Practice may not condition treatment or payment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

Patient Name:_____ Date:_____

Patient or Parent/Guardian Signature:_____