PATIENT MEDICAL RECORD RELEASE FORM

BAY ALLERGY & ASTHMA CLINIC, P.C.
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TODAY'S DATE _____

PATIENT NAME: _____ PATIENT'S DOB _____ LAST APPT:_____

MEDICAL RECORD RELEASE PERMISSION GIVEN

BY: _____ PARENT GUARDIAN PT/SELF

TYPE OF RECORDS WANTED: ☐ **ALL** ☐ **TESTING** ☐ **LAST OV** ☐ **PFT'S** ☐ **INJECTION RECORD**

OTHER_____

_____

_____

MEDICAL RECORDS TO BE RELEASED

TO: _____
(Name of Person/Organization)

_____
(Street Address)

_____
(City, State, Zip Code)

FAX NUMBER: _____

_____ Patient list above has appointment with Dr. _____ on_____ and needs medical records for this appointment.

PLEASE SEND BY: ☐ **FAX** ☐ **MAIL** ☐ **PATIENT/PARENT p/u and deliver**

Please be aware that medical records faxed or mailed by authorization of the patient and/or guardian may not be protecting patient privacy rules and regulations stated in the PHI documentation.

I, the guardian/parent/patient authorize the release of all medical records of the above named patient for future medical needs and/or medical documentation for medical care or opinion of the medical facility named above.

X _____ _____ _____
patient/legal parent or guardian **date** **initials**