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Patient Medical Records Request/Release (Revised 2/2023)

PATIENT INFORMATION: The following information is needed to assist the provider in locating the patient's medical record	
Patient Name:	Patient Date of Birth:
Phone:	Email:

AUTHORIZATION:

❑ I hereby authorize AllergyMD to request records from the Provider below to AllergyMD.
❑ I hereby authorize AllergyMD to release records from AllergyMD to the Provider below.

Provider Name	Provider Phone	Provider Fax	Provider Mailing Address

DESCRIPTION OF INFORMATION FOR REQUEST/RELEASE:

❑ First and Last Visits ❑ Allergy Testing (both skin and blood tests) ❑ Allergy Shot Records* ❑ Other:
❑ Last 12 Months of Visits ❑ Emergency Room Records ❑ Hospitalizations ❑ Other:

*Should include extract name and manufacturer, complete IT composition, vial color/concentration, doses given, intended schedule, any reactions.

Applicable Dates of Service (MM/YYYY to MM/YYYY):

Authorization For Use/Disclosure of Protected Health Information

I understand that the information that I am authorizing AllergyMD to use/disclose may include information related to the diagnosis or treatment of mental illness, substance abuse, chemical dependency, and alcohol abuse, including privileged psychiatric or psychological communications and other detailed mental health information; infectious diseases, such as HIV/AIDS, venereal disease, tuberculosis or hepatitis; and genetic testing or information derived from genetic testing. I hereby waive any privilege concerning such information for the disclosure to the person or entity I have authorized above.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. The patient releases AllergyMD from any and all claims, liabilities, damages, and causes of action whatsoever arising from or related to AllergyMD's use of the patient's medical information pursuant to this medical authorization, or any use or disclosure of such medical information by a third party in connection with the medical services provided to patient by AllergyMD.

I understand that unless otherwise limited by state or federal regulations, I may revoke this authorization at any time by presenting my revocation in writing to the AllergyMD.

Note: There may be fees from the office sending the records to AllergyMD. AllergyMD does not charge for receiving records. These fees are the responsibility of the patient and must be settled with the sending office for AllergyMD to receive the records.

Patient or Legal Representative signature **Please PRINT name** **Date**

As Legal Representative, my relationship to the patient is:_____. Any document proving such authority must be attached.

The patient is unable to sign because:_____.