

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth _____
 Patient's phone #: _____
 Date of Request _____ Date Needed: **ASAP**

<input type="checkbox"/> I authorize Allergy & Asthma Institute of SE Michigan; Comprehensive Food Allergy Clinic to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	OR	<input checked="" type="checkbox"/> I authorize Allergy & Asthma Institute of SE Michigan, Comprehensive Food Allergy Clinic to obtain information from: Phone: _____ Fax: _____
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PURPOSE FOR THIS REQUEST: (Check one.) Healthcare Insurance coverage Personal Other
 Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one.)

Specific information (Select one or more, as applicable)

History & physical **ALL Allergy tests** Vaccine prescription **ALL Laboratory test results**
 X-ray reports **Other** ALL Spirometry
(Please describe.)

- Entire copy of the record checked above.
- Immunization history
- All medical records related to a specific illness or injury.

Specify illness/injury _____ Date(s) of treatment _____

- Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (if requester is not the patient) _____