Allergy & Asthma Institute of SE Michigan

27655 Middlebelt Rd. Ste 100 Farmington Hills, MI. 48334
248-363-3232 Office, 248-363-3455 Fax

Authorization for Release of Medical Information

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

☐ 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

☒ I authorize Allergy & Asthma Institute of SE Michigan, Comprehensive Food Allergy Clinic **to obtain information from**:

Phone: **Fax:**

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)* _____

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