



Allergy and Asthma Associates, P.C.

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RECORD RELEASE AUTHORIZATION

I AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS FROM ALLERGY AND ASTHMA ASSOCIATES, P.C.

TO: _____

ADDRESS: _____

PHONE: _____ FAX: _____

PURPOSE OF RELEASE:

- ☐ CONTINUITY OF CARE ☐ INSURANCE APPLICATION ☐ LEGAL REPRESENTATION
☐ CHANGE OF PHYSICIAN (I will no longer be under the care of Allergy and Asthma Associates, P.C. and my entire chart will be sent to storage)
☐ OTHER _____

PLEASE SEND:

- ☐ Entire medical record ☐ Complete physical and history summary
☐ Pulmonary Function tests ☐ Skin test results
☐ Lab Results ☐ X-Ray or Scan reports ☐ Name of company that provided extracts of allergens
☐ Concentration and list of all allergens in extracts or injections (Please give exact formula for vaccine)

Due to increasing demands for and costs of paperwork in a medical office, a fee is charged for the preparation and transfer of any medical records. I understand that I will be responsible for the following charges, which are allowable under Virginia Law:

- \$10.00 for reviewing, handling and mailing records.
- \$0.50 per page for copying the first 50 pages and \$0.25 per page for the remainder.
- I also understand that payment for records and any outstanding balance on my account will be rendered before records are released.

☐ I wish to be contacted at _____ before my records are copied if the charge is expected to exceed \$25.00.

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure as permitted by law.

(Patient Name)

(DOB)

(Signature, Patient or Parent/Legal Guardian)

(Date)

- (Select one)** ☐ I will pick up my records ☐ Please mail my records to the above address
☐ Please fax my records (An additional fee will be charged for faxing over 10 pages of records)