Allergy and Asthma Associates, P.C.

Sharon Seth, MD Courtney J. Blair, MD Bridget Schaefer, PA-C

RECORD RELEASE AUTHORIZATION

TO: _____

ADDRESS: _____

PHONE: _____ FAX: _____

I AUTHORIZE YOU TO RELEASE MY MEDICAL RECORDS TO: (Select one)

☐ 1360 Beverly Road, Suite #103
McLean, VA 22101
703-356-8290 (P) 703-356-8031 (F)

☐ 46400 Benedict Drive, Suite # 003
Sterling, VA 20164
703-430-0833 (P) 703-430-6073 (F)

PURPOSE OF RELEASE:

☐ CONTINUITY OF CARE ☐ COMMUNICATION ☐ LEGAL REPRESENTATION
☐ CHANGE OF PHYSICIAN ☐ OTHER _____

PLEASE SEND:

☐ Summary of office records (date range) _____
☐ 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)
☐ Allergy shot records ☐ Entire medical record

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party of 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 person 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 many not redisclose them to anyone else without my separate written consent unless recipient is a provider who makes a disclosure as permitted by law.

PATIENT'S NAME:_____ DOB:_____

PATIENT'S ADDRESS: _____

_____ _____
(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 to the above fax number