southwest SWAAA.com asthma & allergy associates

CONSENT FOR RELEASE OF INFORMATION

Date: _____

1. I hereby authorize _____ to release to

   _____ the following information from the health records of:

   _____
   Patient Name

   _____
   Address

   Covering all the periods of care from: _____ to _____

   SSN: _____ Date of Birth: _____

2. Send the information selected below to:

   _____

   _____

   Information to be released:_____ Copy of complete health records
   _____☐_____ Excluding information related to HIV testing and / or results
   _____☐_____ History and Physical
   _____☐_____ Other _____

3. Purpose of disclosure: _____☐_____ to send to insurance company
   _____☐_____ to send to new family / general physician
   _____☐_____ to transfer care to new allergist
   _____☐_____ Other _____

4. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

5. Specification of the date, event of condition upon which this consent expires:

   _____

6. The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: _____ Date: _____
Patient or Representative