Allergy & Rheumatology Associates, LLC

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO ALLERGY & RHEUMATOLOGY ASSOCIATES, LLC

Patient Name_____ Date of Birth_____

I hereby request and authorize you to release my records to Allergy & Rheumatology Associates, LLC as they may request for coordination of care.

_____ _____ _____
Physician Name Phone Fax

Please send the following information from my medical records:

Evaluation & Treatment ☐ Lab Reports ☐ XRAY/MRIs ☐

Consultation Reports ☐ EMG/NCS ☐ Other _____

I understand that I may revoke this authorization at any time by submitting a written request.

_____ _____
Patient Signature Date

If signed by someone other than patient: Print Name: _____

Authority to sign: ◯ Parent or Guardian

◯ Appointed by patient as HIPAA Personal Representative

◯ Other_____