ALLERGY AND ASTHMA CARE, P.A.
12000 ELM CREEK BLVD. # 360
MAPLE GROVE, MN 55369
TEL (763) 420-1010
FAX (763) 420-3710

Name:

DOB:

(Label)

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient:

Name		Date of Birth
Address		Day Phone #
City	State	Zip
Social Security Number		

Provider:

WHO HAS INFORMATION YOU WOULD LIKE RELEASED?		
Name		Phone #
Address		
City	State	Zip

Requestor:

TO WHOM SHOULD THE INFORMATION BE SENT?		
Name		Fax #
Address		
City	State	Zip
E-mail		

Information To be Disclosed:

MEDICAL RECORD RELEASE

Records Concerning: _____
(Specific Diagnosis or Treatment and Specific Dates of Service)

- ☐ Clinic visit notes
- ☐ Consultation/Follow-up Reports
- ☐ X-Ray & Imaging Reports (Chest, Sinus)
- ☐ Lab Reports
- ☐ EKG Reports
- ☐ Allergy Testing
- ☐ Immunotherapy Formulas
- ☐ Immunotherapy Schedules
- ☐ Other (Specify)_____
  _____

Revocation:

I understand that this authorization will be in effect for 12 months unless cancelled by me in writing and that my cancellation will take effect when the provider receives my notice in writing.

Authorization:

I authorize the above provider to release the information marked above to the requestor.	
Patient Signature	Date
If other than patient, please state the relationship and reason patient cannot sign:	