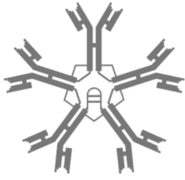

Exton Allergy & Asthma Associates

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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/results

☐ History and Physical

☐ Other ____

3. Purpose of disclosure:

☐ to transfer care to new allergist

☐ to send to new family/general physician

☐ to send to insurance company

☐ 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 (for individuals under age 18 yrs)