UPTOWN ALLERGY & ASTHMA

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MEDICAL RECORD RELEASE

Patient's Full Legal Name: ____________________________________ Date of Birth: ________________

Social Security Number: ________________________ Phone Number: ___________________________

COMPLETE the appropriate section below to SEND **OR** GET health information.

PLEASE SEND HEALTH INFORMATION TO:	**PLEASE GET HEALTH INFORMATION FROM:**
(**Where** do you want the information sent?)	(**Who** has the information you want released?)
____ Name of Provider/Clinic/Organization	____ Name of Provider/Clinic/Organization
____ Street Address	____ Street Address
____ City State Zip Code	____ City State Zip Code
____ Phone Fax	____ Phone Fax

RECORDS to be: ☐ Mailed ☐ Picked Up ☐ Faxed

I authorize ______________________________ to pick up these records on my behalf. I understand a
NAME
photo ID will be required to confirm his/her identity.

I AUTHORIZE the following information to be disclosed (Check those that apply):

[ ] Any and ALL records.

[ ] Records regarding treatment for the following condition or injury
____.

[ ] Records covering the period of time from _________________ to __________________.

ADDITIONAL PATIENT INFORMATION:
If released to myself, I acknowledge this to be my one and only free copy of my medical records. ______ initials
I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to **Uptown Allergy & Asthma LLC**. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **Uptown Allergy & Asthma LLC** may not condition treatment or payment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. This authorization expires six months from the date of the signature. A copy of this authorization will be provided to me upon request.

________________________________ __________________
SIGNATURE DATE