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: _____

CONSENT TO E-SIGNATURES

I agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability and admissibility.

Signature: _____ Date: _____