Justin Clark, D.O., F.A.A.A.A.I.
ALL SEASONS ALLERGY & ASTHMA CENTER
Advanced care to help you breathe better... *for life.*

Patient Name: _____ Date: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD AND INFORMATION

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

Patient information is needed for:
☐ Continuity Medical Care ☐ Military ☐ Social Security/Disability ☐ Insurance
☐ Personal Use ☐ School ☐ Legal Purposes ☐ Other: _____

Information to be released or accessed:
☐ History and Physical ☐ Consultation Report ☐ X-Ray or Imaging Report
☐ Lab or Pathology Report ☐ Other: _____

Dates of Service:
☐ Last 12 months ☐ Last 2 years ☐ Specific Date(s): _____

Release my medical record/information TO:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Release my medical record/information FROM:
Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

I understand that my medical record and information are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as participation in research programs. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. Prior releases of information remain covered under the authorization in place at the time they were released.

I understand that there may be a fee for records released to an individual other than a health care provider.

Signature of Patient/Parent/Guardian: _____ Date: _____
Printed Name of Patient/Parent/Guardian: _____
Relationship to Patient: _____

There will be a copy fee for records released to an individual other than a health care provider. We will require prepayment of $1.00 per page for first 25 pages and $.25 for each additional page, plus actual cost of postage. Prepayment is required before records are released.