CONSENT FOR RELEASE OF MEDICAL INFORMATION

With this form, you authorize the release of your medical health information.

Print neatly and complete all fields.

IDENTIFY YOURSELF

Patient's Last Name	First Name	MI	
Address	City	State	Zip
Phone #	DOB (mm/dd/yyyy)		

IDENTIFY THE FACILITIES SENDING AND RECEIVING YOUR MEDICAL INFORMATION

Allergy and Asthma Comprehensive Care 541 Cedar Hill Avenue Wyckoff, NJ 07481 Phone: (201) 652-6211 Fax: (201)652-0321	☐ is sending information to or ☐ is receiving information from	Name of facility or person: Address: Phone: Fax:

SPECIFY THE INFORMATION TO BE RELEASED

Why do you want the information to be released? _____ For which dates of service do you want medical records released? _____ What categories of information do you wish to have included: ☐ Immunization records and health history only ☐ All medical records **except sensitive documents** (substance or alcohol abuse, domestic violence, sexual assault, HIV related) ☐ All medical records, **including sensitive documents** ☐ All medical records, **except** medical records from other facilities ☐ Other (please specify in writing here what records you are requesting): _____	On what day do you wish this consent to expire? _____ (mm/dd/yyyy) *In order to protect your medical records information, this consent must have a time limit; you are not permitted to grant consent that does not expire. Timeframe cannot exceed one year from date of signature below.* ***If left blank, consent expires 90 days after signature date.*** *You may terminate this consent at any time by sending a written request to the facility/person identified above to release records. Receipt of a termination request will cancel future actions, but cannot reverse the release of information already completed.*

CERTIFY THIS REQUEST

_____

Patient's Signature (or Legal Guardian's if patient is <18) Print Name Date Signed (mm/dd/yyyy)

Relationship to patient (circle one): self parent legal guardian