Allergy & Asthma Wellness
885 Park Avenue Suite 1A
New York City, New York 10075
www.AllergyAsthmaWellness.com

CONSENT TO RELEASE INFORMATION

Patient: _____ _____ Date of Birth: _____
Last First

This will authorize Allergy & Asthma Wellness PLLC to release to _____
Doctor/Company

Address:_____
Email:_____
Phone:_____
Fax:_____

NOTE: Email is an inherently insecure form of communication. Please be aware that any sensitive information transmitted via email may be intercepted by a third party. If you request records to be sent through email, you are accepting the inherent security risks associated with email.

INFORMATION REQUESTED:

□Allergy Testing
□Breathing Tests
□Labs
□Clinical Summary
□Immunization Records
□X-Ray/CT Reports
□Immunotherapy Schedule
□Complete Records (fees apply for +15 pages)
□Other _____

REASON FOR RELEASE:

□To update my regular doctor (provider)
□I have been referred to another doctor
□I want/need a second opinion
□I am changing doctor (provider)
□I am moving
□My insurance changed

CONFIDENTIAL INFORMATION

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or contains HIV related information, you must specifically authorize the release of such information by INITIALING the following three:

_____I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

_____I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form.

_____This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

Signed By: _____ _____
Signature of Patient/Legal Guardian Relationship to patient

_____ _____
Print Name of Patient/Legal Guardian Date:

This form will expire 3 months from signed date