Portland Allergy & Asthma

OUTGOING RECORDS RELEASE

Patient Name:_____DOB:_____

I hereby authorize Portland Allergy and Asthma, LLC, to release a copy of my medical records to the following Provider/Practice:

Provider Name:_____Phone:_____

Street Address:_____FAX: _____

City:_____State:_____Zip:_____

I authorize the release of the following records:

☐ My entire health record ☐ Allergy Shot prescription

☐ Allergy Shot Record ☐ Allergy extract vials(fee associated)

☐ Specified Information only: _____

Reason for request:

☐ Moving

☐ Personal use

☐ Changing Providers

☐ Allergy shots to be given by another provider.

Disclosure: I understand that Portland Allergy and Asthma cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information

_____ _____

Patient/Guardian Signature Date