Portland Allergy & Asthma

Release of Information

Patient Name:_____ **DOB:**_____

I hereby authorize:_____
Name of Provider To Release Records

To release my records to:
Name of Provider Requesting Records

Provider Name:_____**Phone:**_____

Street Address:_____ **Fax:**_____

City:_____**State**:_____**Zip:**_____

I authorize the release of the following records:

- Entire Health Record
- Allergy Shot Record
- Allergy Shot Prescription
- Allergy extract vials
- Specified Information Only:_____

Reason for Request:

- Moving
- Personal Use
- Transferring Care

Disclosure: For outgoing records,I understand that Portland Allergy and Asthma cannot guarantee that the recipient will not re-disclose 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: