



Release of Information

Patient Name: _____ DOB: _____

I hereby authorize:

Name of Provider To Release Records

Provider

Name: _____ Phone: _____

Street Address: _____ Fax: _____

City: _____ State: _____ Zip: _____

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

This authorization is valid for 1 year from the date of signature.

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: