The Allergy Group

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Board Certified in Pediatric and Adult Allergy, Asthma & Immunology
Clinic locations in Boise, Meridian, Nampa, Eagle and Caldwell
Website: www.theallergygroup.com
Email: info@theallergygroup.com
Phone: 208.377.4000 Fax: 208.375.8426

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME:_____ Maiden/other name:_____

DATE OF BIRTH:_____ SSN: _____

PATIENT RECORDS **From**:_____
Physician/Medical Office

_____
Address State

_____
State Zip Phone/Fax

I hereby authorize and request the release of the following information:
___ All Patient Information
___ Patient Information for visit date(s) of _____to_____
___ All Billing Statement
___Other (specify):_____

PLEASE SEND MY RECORDS TO: The Allergy Group
1000 N. Curtis Road Suite 303
Boise, ID 83706
Phone (208)377-4000
Fax (208)375-8426

Purpose for release of information: _____

Upon request, you may limit the amount of time that this consent for release of information is valid. You may revoke his authorization and writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sinus authorization and note that I do not need to sign to short treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimile of this authorization shall be considered to be the same as assigned original document.

Signature: _____ Date: _____

Relationship to patient (If parent of guardian)_____

Office Use Only Released:
Date_____ To: _____ By:_____
Date_____ To: _____ By:_____