Authorization for Release of Medical Records to Atlanta Allergy & Asthma

MEDICAL INFORMATION REQUEST AUTHORIZATION

The undersigned patient,____(print name), seeks medical treatment and/or is under evaluation for a clinical trial from Atlanta Allergy & Asthma, P.A. & RX Research ("Atlanta Allergy"), and in furtherance of such treatment or study hereby authorizes ____ (name of physician or practice) to release to Atlanta Allergy copies of the following medical records of patient within Physicians possession or control:

- ❑ Entire Patient Chart
- ❑ History and Physical
- ❑ Consultation Reports
- ❑ Laboratory Reports
- ❑ All Skin Test/RAST Results
- ❑ Exact Composition Allergenic Extract: Antigens, Concentration and Manufacturer
- ❑ Discharge Summary
- ❑ Progress Notes or Summary
- ❑ Pulmonary Function Studies
- ❑ X-ray Reports

By signing below, patient understands that he/she is authorizing the disclosure by Physician of his/her confidential and privileged medical information, including protected health information ("PHI"), as such term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such information includes personal information about the patient, including age, gender, race, date of birth, social security number and address, as well as patient's personal medical history, including diseases, afflictions, addictions, diagnoses, surgeries, disabilities and symptoms. **THE PATIENT RELEASES ATLANTA ALLERGY & ASTHMA AND PHYSICIAN FROM ANY AND ALL CLAIMS, LIABILITIES, DAMAGES AND CAUSES OF ACTION WHATSOEVER ARISING FROM OR RELATED TO ATLANTA ALLERGY'S USE OF THE PATIENT'S MEDICAL INFORMATION PURSUANT TO THIS AUTHORIZATION, OR ANY USE OR DISCLOSURE OF SUCH MEDICAL INFORMATION BY A THIRD PARTY IN CONNECTION WITH THE MEDICAL SERVICES PROVIDED TO PATIENT BY ATLANTA ALLERGY.**

The patient acknowledges that this Authorization shall remain in effect indefinitely until such time as it is withdrawn in writing by patient.

Patient/Parent Signature: ____ Date : ______________

Print Name: ____

Patient DOB: _______________________

Office location for Information to be sent to:

Mailing Address: ____ Fax: ____________________________

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Contact Person: ____ Phone: ____________________________