AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION

I hereby authorize the organization below to release medical records for:

Patient Name: _____ DOB: _____

FROM:

DMV Allergy and Asthma Center
4660 Kenmore Ave Ste. 419
Alexandria, VA 22304
O: 703-997-0811 F: 703-997-0820

TO:

_____
The organization authorized the release of information.

_____
Street Address

_____
Phone Number

_____
Fax Number

Information requested:

□ Labs
□ Progress Notes
□ Testing Results
□ Other _____

_____ _____
Patient Signature Date
Phone Number

_____ _____
Parent/Guardian Signature Relationship to Patient

I understand that the medical records to be released may contain protected health information (PHI) related to Hepatitis, HIV status, AIDS, sexually transmitted disease, alcohol and/or drug use or mental health services; and hereby authorize the release of this information. ALL information released will be handled confidentially. The authorization for disclosure is specific for this request only and is valid for one year from the date of authorization. I may withdraw this authorization at any time except to the extent that action has been taken in response thereon.