Mark R. Stein, M.D.
Alan Koterba, M.D., Ph.D.
Elena E. Perez, M.D., Ph.D.
Cathy Hollowell, ARNP

Allergy Associates

Adult/Pediatric Allergy & Immunology

Patient Request for Release of Healthcare Information

Date:_____

Patient Name_____Date of Birth_____Phone_____

Address_____City_____State_ Zip_____

I **request that my protected health information (PHI) is please circle:** **RELEASED TO:** **OBTAINED FROM:**

Recipient_____Phone_____Fax _____

Address_____City_____State ____ Zip _____

I **authorize the following PHI to be released from my medical record(s):**

Lab Results CT Scans/Chest X-Rays
Office Note Allergy Test results
All of the above Biopsy Other: _ _ _ _ _ _ _ _ _ _ _

Date range: ____ **to:** ____ **OR** specific date(s) of service:_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

Purpose for requesting information: Personal legal Insurance Transfer or continuation of care
Disclosure format (paper is default if not marked) Paper-US mail Fax
by signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition._____*or* will expire _____ From the date signed.
  Insert time frame
- I have a right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Medical Records Department at 840 US Highway One, Suite 235, North Palm Beach, FL 33408. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries the potential for unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules.

_____ _____ _____
Patient or Authorized Representative Signature Print Name Date

_____
Relationship to patient

Office use only: ***Account#*** ***MR#*** ***Completed by/date***

Rev.10/2016

Fax: 561-626-8622

Discrimination is Against the Law-
Allergy Associates of the Palm Beaches, PA (AAPB) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability, or sex.
AAB does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Allergy Associates ofThe Palm Beaches cumple con las leyes federales de derechos civiles aplicables y no discrimina par motives de raza, color, nacionalidad, edad, discapacidad o sexo.
Allergy Associates of The Palm Beaches no excluye a las personas ni las trata de forma diferente debido a su origen etnico, color, nacionalidad, edad, discapacidad o sexo.
ATTENTION: If you need language assistance services, the office will provide free of charge. Please call 561-626-2006.
ATENCION: si habla espafiol, tiene a su disposici6n servicios gratuitos de asistencia lingufstica. Llame al 561-626-200