ALLIGATOR
ALLERGY & ASTHMA

4194 Royal Pine Drive
Colorado Springs, CO 80920

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_______________________________________ **Date of Birth:**_______________

Home: _________________________ **CELL:** ____________________________

Address: ____

STREET NAME CITY STATE ZIP

The above listed patient authorizes the following healthcare facility to release his/her records:

Facility Name: ___________________________________ **Facility Phone:** ___________________________

Provider Name: __________________________________ **Facility Fax:** _____________________________

Facility Address:____

STREET NAME CITY STATE ZIP

Dates and Type of information to be disclosed:
2 years prior from last date seen
Specific information: ______________________________
Other: ____
Office Notes, Allergy Test, Labs, Imaging Reports, etc.

The purpose of disclosure is:
Allergy and Asthma Consultation & Evaluation
Continuation of Care
Change of Insurance or Physician
Referral

Release Records are disclosed to:

Alligator Allergy & Asthma
ATTN: Christianne McGrath MD
4194 Royal Pine Drive Suite 100, Colorado Springs, CO 80920
Please fax records to: (844) 269-5420

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information specifically requested by the patient named on this form. **I understand the information in my health record may include information relating to sexually transmitted disease(STD), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.** I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date,event or condition: ______________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed**.

I understand that authorizing the disclosure of this health information is voluntary and i can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.
I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X____
Signature of Patient / Parent / Guardian or Authorized Representative Date

(Guardian or Authorized Representative must attach documentation of such status.): ____
Printed name of Authorized Representative Relationship / Capacity to patient

Address and telephone number of authorized representative: ____