



Allergy & Rheumatology Associates, LLC

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO ALLERGY & RHEUMATOLOGY ASSOCIATES, LLC

Patient Name _____ Date of Birth _____

I hereby request and authorize you to release my records to Allergy & Rheumatology Associates, LLC as they may request for coordination of care.

Physician Name Phone Fax

Please send the following information from my medical records:

Evaluation & Treatment _____ Lab Reports _____ XRAY/MRIs _____
Consultation Reports _____ EMG/NCS _____ Other _____

I understand that I may revoke this authorization at any time by submitting a written request.

Patient Signature Date

If signed by someone other than patient: Print Name: _____

Authority to sign: _____ Parent or Guardian
_____ Appointed by patient as HIPAA Personal Representative
_____ Other _____