Allergy Specialist of Palm Beaches

Attn: Tanuja Vedere, M.D.
1801 S.E. Hillmoor Dr C- 107
Port St. Lucie 34987

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORDS

This authorization to receive or release information is being requested of you to comply with HIPPA.

PATIENT'S NAME: _____ BIRTH DATE:_____

SOC. SEC. NO._____PHONE (WORK)_____(HOME)_____

I HEREBY AUTHORIZE:

Allergy Specialist of Palm Beaches

Attn: Tanuja Vedere, M.D.
1801 S.E. Hillmoor Dr C- 107
Port St. Lucie 34987

TO RELEASE INFORMATION TO:

NAME OF THE PERSON OR ORGANIZATION RELEASING INFORMATION:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

THIS RELEASE LIMITS DISCLOSURE TO: ☐ ALL RECORDS (OR)

☐ LAB ☐ X-RAYS /CT SCANS ☐ IMMUNIZATIONS ☐ SKIN TEST RESULTS ☐ PATCH TEST

☐ SPIROMETRY ☐ SKIN BIOPSY ☐ OTHER_____

INFORMATION NOT TO BE RELEASED, IF ANY:_____

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING(PLEASE INITIAL THE COLUMNS IF THIS INFORMATION IS TO BE INCLUDED)

	YES	NO	INITIALS
HIV INFORMATION			
DRUG/ALCOHOL INFORMATION			
MENTAL HEALTH INFORMATION			

THIS INFORMATION IS REQUIRED FOR:

☐ SECOND OPINION ☐ REFERRAL ☐ RESIDENCE RELOCATION ☐ INSURANCE CHANGE

☐ CONTINUITY OF CARE ☐ OTHER (PLEASE SPECIFY)_____

THIS AUTHORIZATION SHALL BE VALID UNTIL_____. PLEASE INDICATE THE DATE AFTER WHICH NO INFORMAITON CAN BE RELEASED. IF NO DATE IS GIVEN, CONSENT IS VALID FOR 90 DAYS ONLY.

I MAY REVOKE THIS AUHTORIZATOIN AT ANY TIME, IN WRITING, BEFORE THE INFORMATION HAS BEEN RELEASED. I FURTHER UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON REQUEST.

COPY REQUEST: ☐ YES ☐ NO COPY RECEIEVED: ☐ YES ☐ NO

PARENT/ GUARDIAN/ AUTHORIZED REPRESENTATIVE'S SIGNATURE:_____

DATE:_____

PATIENT/PARENT/GUARDIAN NAME (PRINTED):_____