TIDEWATER
ALLERGY & ASTHMA

Medical Records Release Authorization

Patient Name: _____ DOB: _____

Address: _____

Email Address: _____ Phone: _____

I authorize release of the following information, including for continuation of care:

☐ My health record, including notes, skin tests, radiologic results, and lab results

☐ Other (please specify below):

_____

This authorization will expire 12 months from the date of signature unless I indicate a different date here: ____

If requesting that medical records from another office be sent to Tidewater Allergy, please list details below:

From which medical office are you requesting records? _____

Address: _____

Phone Number: _____ Fax Number: _____

If requesting that medical records from Tidewater Allergy be sent to another entity, please list the recipient below:

Recipient's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign it and I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it.

Signature: _____ Date: _____

Printed Name: _____

Patient's Name (if signing as authorized person): _____

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