

A&A Allergy & Asthma
of Southern Indiana, P.C.

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Board Certified
Pediatrics Internal Medicine
Pediatric & Adult Allergy & Immunology

Release of Medical Records Authorization

I hereby authorize Allergy & Asthma of Southern Indiana, P.C. to
release my Medical Records to:

Name: _____

Street Address: _____

City State Zip Code

Patient Name: _____ Date of Birth: ___/___/___

Street Address: _____

City State Zip Code

Please send the following records:

- Complete Medical Records
- Skin Testing Results
- Lab Work
- Radiology Reports
- Pulmonary Function Results
- Other _____

Purpose of Disclosure: _____

Special Notes: _____

This authorization expires one year from the date below, but I understand that I have the right to revoke this authorization in writing at any time. This however, would not affect any disclosures that were permitted/made while this authorization was in effect. I further understand that my Protected Health Information that is used or disclosed under this authorization may be subject to redisclosure by the recipient, and the privacy of my Protected Health Information will no longer be protected by the law.

Patient or Legal Guardian Signature: _____

Date: ___/___/___ Witness Signature: _____