SAN TAN Allergy & Asthma

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MEDICAL RECORDS RELEASE FORM

Patient Information (please print)**:**

Name: _____DOB:_____

Address: _____

☐ **REQUEST** records from the following: ☐ **RELEASE** STAA records to the following:

Entity:_____
(Name of person or organization)

Phone number:_____Fax:_____

Email: _____Address: _____

City: _____State:_____Zip code:_____

□ Visit Notes	□ Injection Record	□ Pulmonary Function Tests
□ Lab Results	□ Serum Recipe (Extract Formula)	□ Pathology Reports
□ Imaging and Diagnostic Reports	□ Skin Test Results	□ Biopsy Results
□ Sleep Study Report	□ All Office Records	□ Outside Medical Records

□ Other: _____

Preferred method of transmission (circle one): Fax / Mail / Email

I hereby authorize San Tan Allergy and Asthma to release or obtain medical records from the period _____ to _____. I understand that this authorization covers all records, including those related to communicable diseases, AIDS, HIV, behavioral and/or mental health care (excluding psychotherapy notes), substance abuse and/or addiction treatment, and genetic testing, if any such records exist. I understand that this authorization will expire 12 months after the date of signing unless an earlier date is specified here: _____. I understand that I may be charged a reasonable fee in accordance with state law.

Signature:_____Date:_____
Parent or guardian signature: (if patient is under 18)