Allergy and Asthma Specialists of Frederick

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of **patient** (print clearly): _____
DOB:_____ Phone: _____

I authorize the release of my/my child's private health information as below:

FROM:
Name _____
Address_____
_____
Phone _____
FAX _____

TO:
Alpa Jani, MD
Allergy and Asthma Specialists of Frederick
5300 Westview Dr., Suite 102
Frederick, MD 21703
FAX 240-831-4539

Please release the following documentation from the year 2000 to the present:
ALL **skin testing** results, **spirometry** results, and **progress notes** and
ALL **lab test results**, **imaging results**, **biopsy results**, **notes from outside providers**, and **allergy shot records** and **extract recipes**,
for the purpose of continued medical care by Dr. Alpa Jani and the Allergy and Asthma Specialists of Frederick.

I understand this authorization expires 3 years from the date of signature, and I have the right to revoke the authorization at any time.

Signature: _____
Parent/Guardian Name & Relationship (if patient is a minor):
_____

Date: _____