

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:

(circle one) TO/FROM:

Name _____

Address _____

Phone _____

FAX _____

(circle one) TO/FROM:

Alpa Jani, MD

Allergy and Asthma Specialists of Frederick

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Frederick, MD 21703

Phone 240-831-4743

FAX 430-206-1822

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.

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: _____