Authorization and Consent for Release of Medical Information

Patient Name_____ Birth Date: _____ Chart#_____
(Please Print)

Other Name(s) Used: _____ Phone # _____

Information Released From:
(Please complete or check below)

_____

_____

_____

Or
__ Minnesota Allergy & Asthma Clinic, PA

Information Released/Information Access To:
(Please complete or check below)

_____

_____

_____

Or
__ Minnesota Allergy & Asthma Clinic, PA
Phone # (952) 223-3050
Fax # (952) 223-3041

__ All Medical Records
Or all of the following information is to be released that is checked below.

___ Initial Allergy History and Physical Record ___ Allergy Progress Notes ___ Laboratory Studies

__ Pulmonary Function Testing (Spirometry) ___ Oral Challenge ___ Skin Testing

___ Methacholine or Other Pulmonary Challenge Testing ___ Patch/Venom Testing ___ Radiology Reports

THE FOLLOWING APPLIES ONLY IF YOU WOULD LIKE ALLERGY INJECTION THERAPY SERUM AND INJECTION RECORDS MAILED TO ANOTHER CLINIC.

__ Allergy Injection Record (Original Orders and last 24 months of Injections) **MAAC SERUM MUST BE MAILED DIRECTLY TO THE CLINIC. PATIENTS MAY NOT HAND-CARRY MAAC SERUM.**

__ Unless otherwise indicated by a check mark, all records pertaining to psychiatric/mental health, chemical dependency and or AIDS/HIV related illness/testing will not be released.
__ This information will be used for: (Check One) Transfer of care to another Physician ___ Other:_____

PLEASE INITIAL THE FOLLOWING:
__ I understand that I may revoke this consent at any time and that the consent will automatically expire one year from the date of my signature.

__I understand that a **photocopy or FAX** of this authorization will be treated in the same manner as the original.

__ I do not authorize further release by the receiving requestor to any third party. I understand that once information is released pursuant to this authorization, the facility or physician named above cannot prevent the re-disclosure of that information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Authorized Person Date Relationship to Patient

Reason Patient is Unable to Sign: __ Minor __ Deceased __ Other

Return this request for Medical Records To:

Minnesota Allergy & Asthma Clinic, PA
350 West Burnsville Pkwy, Suite 200
Burnsville, MN 55337-4559
Attn: Medical Records
Fax: 952-223-3041

OFFICE USE ONLY:

Request forwarded to: _____

Date: _____
Initials: _____