Allergy & Asthma CONSULTANTS

Breathe easier with rapid allergy and asthma relief.

Creve Coeur:
711 Old Ballas Road, Suite 100
Creve Coeur, MO 63141
Phone: 314.569.0510 Fax: 314.569.1085

St. Peters:
3701 N. St. Peters Parkway, Suite C3
St. Peters, MO 63376
Phone: 314.569.0510 Fax: 314.569.1085

Authorization to Release Medical Records

Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip:_____

I authorize to disclose the following medical information *to*:

Name :_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I authorize to disclose the following medical information *from*:

Name :_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This authorization extends only to documents initialed below:

_____ Progress Notes
_____ Consultation Reports
_____ History & Physical Examination
_____ Lab Results Type of test: _____ Date: _____
_____ X-Ray Reports Date taken: _____ Date: _____
_____ Mental Health and/or alcohol and drug abuse treatment
_____ AIDS/HIV/Hepatitis Information
_____ Other (Must be specific) _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization.
2. A photocopy of fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for sixty (60) day period from the date it is signed.
4. Allergy & Asthma Consultants, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____

Print Patient's Name

_____ _____

Patient's Signature (or Guardian, if minor) *Date*