Allergy and Asthma Institute of Southeast Michigan

7010 Pontiac Trail, Suite B, West Bloomfield, MI 48323
248-363-3232 Office, 248-363-3455 Fax

# Authorization for Release of Medical Information

Patient's name_____ Date of Birth: _____
Address_____
City/State/Zip Code_____Patient's phone #: _____
**Date of Request**_____**Date Needed: ASAP**

☐ I authorize Allergy & Asthma Institute of SE Michigan; Comprehensive Food Allergy Clinic **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

☒ I authorize Allergy & Asthma Institute of SE Michigan, Comprehensive Food Allergy Clinic **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

**PURPOSE FOR THIS REQUEST:** (Check one.) ☐ Healthcare ☐ Insurance coverage ☐ Personal ☐ Other ☐ Transfer of Care

**TYPE OF RECORDS REQUESTED:** (Check one.)

☐ Specific information (Select one or more, as applicable)
☒ History & physical ☒ Allergy tests ☒ Vaccine prescription ☒ Laboratory test results
☐ X-ray reports ☐ Other _____
(Please describe.)

☐ Entire copy of the record checked above.
☐ Immunization history
☐ All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

☐ Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

***I understand that:***

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____

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