nyasc Allergy & Sinus Centers
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Patient: _____ _____ **Date of Birth**:_____
Last First

☐ **This will authorize NYASC to release to:**

Doctor_____

Address_____

_____

Telephone_____

Fax_____

☐ **This will authorize your doctor:**

Dr. _____to release to New York Allergy & Sinus Centers.
Fax_____

Telephone_____

☐ **This will authorize New York Allergy & Sinus Centers to release to PATIENT:**
- ☐ Pick Up (select location below)
- ☐ Third Party _____
- ☐ Email _____

NOTE: Email is an inherently insecure form of communication. Please be aware that any sensitive information transmitted via email may be intercepted by a third party. If you request records to be sent through email, you are accepting the inherent security risks associated with email.

Medical Information Requested:
- ☐ Most Recent Clinical Summary
- ☐ Allergy Testing
- ☐ Breathing Tests
- ☐ Final Lab Results
- ☐ CT Report
- ☐ Immunotherapy Schedule/Extract Formula
- ☐ CT Films/CT (fees may apply)
- ☐ Complete Records (fees may apply 75 cents/page)
- ☐ Other_____

Reason for Release:
- ☐ To update my Primary Care Doctor/ENT
- ☐ I have been referred to another doctor
- ☐ I want/need a second opinion
- ☐ To update my specialist
- ☐ Dissatisfaction with care
- ☐ My insurance changed
- ☐ I am moving

Confidential Information

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or contains HIV related information, you must specifically authorize the release of such information by INITIALING the following three:

_____I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

_____I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form.

_____This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

_____ _____ _____
Signature of Patient/Legal Guardian (Required) Relationship to patient Date

This form will expire 1 year from signed date