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Patient: Last First Date of Birth:

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 3 months from signed date

116 East 36th Street New York, NY 10016
225 East 57th Street New York, NY 10022
336 Central Park West New York, NY 10025
154 West 14th Street 4th Fl. New York, NY 10011

190-02 Jamaica Avenue Hollis, NY 11423
135 East 83rd Street New York, NY 10028
79-49 Myrtle Avenue Glendale, NY 11385
211 Central Park West New York NY, 10024