AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: Intermountain Allergy & Asthma

to release to: _____

Address: _____

_____

the following data from my medical records:

_____ Evaluation and treatment summary
_____ X-Ray report
_____ Actual skin test results (copy of testing sheet preferred)
_____ Actual formula of treatment extract and injection record
_____ Any other consultation reports
_____ All medical records on file
_____ Other (please specify) _____
_____

RE: _____
(last name) (first) (maiden) (middle)

_____
(address) (zip) (phone)

Birthdate_____ Approximate dates treated _____

Admitting physician, if hospitalized _____

Reason for the request: _____

_____

This is a single use authorization that expires upon completion of the request. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. This authorization may be revoked by sending a written request prior to the expiration event.

_____ _____
(Witness) (Signature of patient or responsible party)

_____ _____
(Date) (Relationship to patient)