ALLERGY AND ASTHMA ASSOCIATES, PLLC

AUTHORIZATION TO USE, DISCLOSE, & RELEASE PROTECTED HEALTH INFORMATION

I authorize Allergy and Asthma Associates, PLLC (1200 112th Ave NE, C210, Bellevue, WA 98004, 425-454-2191; www.allassoc.com) to use and disclose a copy of the specific health information described below regarding:

Patient's Name: _____ DOB: _____

Patient's Address: _____ Phone: _____

_____

Send records to:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

For the range of dates from: _____ to: _____

For information related to the following diagnosis or diagnoses: _____

_____

Information to be disclosed:

☐ **history & physical; progress notes** ☐ **allergy shot records and antigen vials**

☐ **test/diagnostic reports (skin test, lab, x-ray)** ☐ **my Xolair medication**

For the purpose of: _____

I understand there may be a modest and customary fee for processing and transferring records.

Patient Signature: _____ Date: _____

Legal Guardian or Patient Representative:

Name: _____ Date: _____

Signature: _____ Relation to Patient: _____