D. L. Southern, M.D. A. Pedinoff, M.D. J. Caucino, D.O.
H. Skolnick, M.D. K. Sikorski, M.D. S. Shah, M.D. N. Baman, M.D.

Princeton 609-921-2202 Plainsboro 609-799-8111
Hamilton 609-888-1555 Flemington 908-782-0093
Fax #: 609-924-1468

Records Release Authorization

Patient Name: ____ DOB: ____________________

Street Address: ____

City/State/Zip Code: ____

SS#: ____________________________________ Phone #: ________________________________

Date of Request: ______________________________ Date Needed: ____________________________

☐ I authorize Princeton Allergy & Asthma **to release information to*:**	OR	☐ I authorize Princeton Allergy & Asthma **to obtain information from:**
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone #/Fax # (include area code)		Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one) ___ Personal ___ Healthcare ___ At patient's request

TYPE OF RECORDS REQUESTED: (Check one)

☐ All medical records including any records in these subject areas:

- ☐ Allergy testing
- ☐ PFT (Pulmonary Function Testing)
- ☐ Labs (Dates: ________________)
- ☐ Diagnostic Imaging (Dates: ____________)
- ☐ Other ______________________________
- ☐ HIV/AIDS
- ☐ Sexually transmitted diseases
- ☐ Mental illness or mental health treatment
- ☐ Drug and alcohol abuse treatment

AUTHORIZATION VALID FOR: (Check one)

☐ This request only.

☐ One year from the date of this authorization OR __________. (insert date.) This authorization applies to the records for the treatment received on or prior to the date of this authorization.

☐ This request **and** for medical records of any future treatment of the type described above until: _________ (insert date.)

____ I will continue to be an active patient.

____ I will no longer be a patient. Please state the reason you are leaving our practice ____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may revoke this authorization at any time by submitting a *written* request to the address provided at the side of this form, except where a disclosure has already been made in reliance on my prior authorization.
- I release staff and counsel from all legal responsibility or liability that may arise from authorized release of information.
- If the person or facility receiving this information is not a health care of medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- This authorization will include the release of information concerning HIV testing or treatment of AIDS, AIDS related conditions, drugs or alcohol abuse, drug related conditions, alcoholism, and /or psychiatric or psychological conditions.
- There may be a charge for the requested records.

Signature of patient or legal guardian ____ **Date**____________________

***A $10.00 processing fee applies to the above request. Any records over 10 pages will be charged $1.00 per page.**

If you would like to pay your records fee by credit card, please do so below.

___MC ___Visa ___Disc ___Amex Card # ____ Exp Date ________________

Name on card ____ Signature ____ 4/28/21