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Fax #: 609-924-1468

Records Release Authorization

Patient Name: _____ DOB: _____
 Street Address: _____
 City/State/Zip Code: _____
 SS#: _____ Phone #: _____
 Date of Request: _____ Date Needed: _____

<input type="checkbox"/> I authorize Princeton Allergy & Asthma to release information to*: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	OR	<input type="checkbox"/> I authorize Princeton Allergy & Asthma to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)
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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:
- | | |
|--|--|
| <input type="checkbox"/> Allergy testing | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> PFT (Pulmonary Function Testing) | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Labs (Dates: _____) | <input type="checkbox"/> Mental illness or mental health treatment |
| <input type="checkbox"/> Diagnostic Imaging (Dates: _____) | <input type="checkbox"/> Drug and alcohol abuse treatment |
| <input type="checkbox"/> Other _____ | |

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 _____ 1/21/22