PRINCETON
ALLERGY & ASTHMA ASSOCIATES, P.A.

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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*:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

☐ I authorize Princeton Allergy & Asthma **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip 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 $15.00 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 _____ 7/14/25