LTD.
ALLERGY & ASTHMA CONSULTANTS, LTD.

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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: (If 18 or older) _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **Allergy & Asthma Consultants, Ltd.**

Address: **( CIRCLE ADDRESS ABOVE )**

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

**X**_____ **Relation to patient?:** SELF / PARENT / LEGAL GUARDIAN

**(PRINT YOUR NAME CLEARLY)**

**Patient/Guardian Signature:** **X** _____ **Date Signed:** **X** _____

***THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.***