



MARK E. KAPLAN, M.D.
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Authorization for Release of Information

Patient Name: _____ Date of Birth: ____ / ____ / ____
 Address: _____ Phone: _____
 City, State, Zip: _____

| | |
|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> I authorize Allergy & Asthma Consultants, LTD to release TO: | <input type="checkbox"/> I authorize Allergy & Asthma Consultants, LTD to obtain FROM: |
| _____ Name of Person, Provider or Facility | _____ Name of Person, Provider or Facility |
| _____ Address | _____ Address |
| _____ City, State, Zip Code | _____ City, State, Zip Code |
| _____ Phone # / Fax # (include area code) | _____ Phone # / Fax # (include area code) |

Records sent to Allergy & Asthma Consultants, LTD can be faxed and/or mailed to:

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Allergy & Asthma Consultants, LTD 36100 N. Brookside Drive, Suite 203 Gurnee, IL 60031-4573 847-855-1570 847-855-1890-FAX | <input type="checkbox"/> Allergy & Asthma Consultants, LTD 1800 Hollister Drive, Suite 106 Libertyville, IL 60048-5265 847-549-7711 847-549-1020-FAX |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

PURPOSE OF REQUEST: (Check one) Healthcare Personal Other (Specify) : _____

SPECIFY INFORMATION TO BE RELEASED: (Select one or more as appropriate)

For dates of service?: ____/____/____ to ____/____/____ or ALL DATES

- Progress Notes
- Laboratory Test Results
- Allergy Skin Test Results
- Diagnostic Test Results
- OTHER _____

One-time Use/Disclosure: I authorize this one-time disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

I would like this authorization to expire:

- When the requested information has been sent/received
- 90 days from the signature date on this form
- OTHER: _____

Printed Name of Patient or Parent/Legal Guardian: _____ Date: _____

Signature of Patient or Parent/Legal Guardian: _____ Date: _____

Relationship to Patient (if requester is not the patient): Parent Guardian OTHER: _____