MARK E. KAPLAN, M.D.
STACIE A. McMURTRY, M.D.
SANDRA DENMAN, PA-C

Authorization for Release of Information

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

☐ **I authorize Allergy & Asthma Consultants, LTD to release TO:**	☐ **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:

☐ **Allergy & Asthma Consultants, LTD**
36100 N. Brookside Drive, Suite 203
Gurnee, IL 60031-4573

847-855-1570
847-855-1890-FAX

☐ **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) :** ______________________

☐ For dates of service?: ALL DATES or _____/_____/_____ to _____/_____/_____

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

☐ All Records
☐ Progress Notes
☐ Laboratory Test Results
☐ Allergy Skin Test Results
☐ Diagnostic Test Results
☐ OTHER ______________________

I WOULD LIKE THIS AUTHORIZATION TO EXPIRE:

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