



Office: 702-735-1556 | Fax: 702-737-7495
www.snallergy.com

Authorization for Release of Medical Records

Patient Information				
Patient's Last Name:	First:	MI:	Birth Date:	Social Security Number:
Release From/To				
<input type="checkbox"/> From <input type="checkbox"/> To Southern Nevada Allergy Phone: 702.735.1556 Medical Records Fax: 702.737.7495		<input type="checkbox"/> From <input type="checkbox"/> To Name: Address: Phone: Fax:		
Information to be Released				
<input type="checkbox"/> All Records <input type="checkbox"/> Problem List <input type="checkbox"/> Xray Reports <input type="checkbox"/> Progress Notes <input type="checkbox"/> Lab Reports <input type="checkbox"/> History & Physical Exam <input type="checkbox"/> EKG Reports				

Notice

- I understand this information is voluntary.
- I understand that e-mailed copies of medical records will be sent to an e-mail address I provide using an unencrypted server and Greater Austin Allergy, Asthma & Immunology is not responsible for records reaching any unintended recipients.
- I may revoke this authorization at any time, provided that I do so in writing and submit it to Southern Nevada Allergy, Asthma & Immunology. The revocation will take effect when Southern Nevada Allergy, Asthma & Immunology receives it, except to the extent that Southern Nevada Allergy, Asthma & Immunology or others have already relied on it.
- I am entitled to receive a copy of this authorization.
- Unless revoked, this authorization will expire twelve (12) months after the date of signing this form.

Printed Name:	Phone Number:
Signature of Patient or Responsible Party:	Date:
If signed by someone other than the patient, indicate relationship to the patient:	
Provider requesting medical records:	