Phone: 702.735.1556

SOUTHERN NEVADA ALLERGY

ALLERGY | ASTHMA | IMMUNOLOGY

Fax: 702.737.7495

Authorization for Release of Medical Records

Patient Information		
Patient's Last Name: First: MI:	Birth Date:	Social Security Number:

Release From/To	
□ From □ To Southern Nevada Allergy Phone: 702.735.1556 Medical Records Fax: 702.737.7495	□ From □ To Name: Address: Phone: Fax:

Information to be Released
□ **All Records** □ Problem List □ Xray Reports □ Progress Notes □ Lab Reports □ History & Physical Exam □ 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:	