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ADULT AND CHILDHOOD
ASTHMA AND ALLERGY

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SATELLITE CLINICS IN EAGLE NAMPA AND CALDWELL

Consent to Obtain Medical Records

Patient Name: _____ Date of Birth: _____

I give consent for my medical information to be released

From:	**To:**
_____	_____
_____	_____
_____	_____

Please send the following records:

- ❑ Office notes
- ❑ CT Films
- ❑ Operative Report
- ❑ CT Report
- ❑ Pathology
- ❑ Mail Extract
- ❑ Lab Report(s)
- ❑ Allergy Test

Purpose for Medical Records:

- ❑ Insurance
- ❑ Second Opinion
- ❑ Other: _____
- ❑ Transfer to another MD
- ❑ Moving out of the area

Expiration of Consent:

This consent will expire:

- ❑ After a one-time release of information
- ❑ As of this date: _____
- ❑ Other: _____

I understand that I have the right to revoke this consent at any time. Exceptions to revoking this consent are (1) if this facility has already acted on the initial consent prior to my revocation and (2) if the consent was obtained as a condition of obtaining insurance coverage. I also understand that the information disclosed to the person or entity indicated above may be subject to re-disclosure by the recipient and is no longer protected by the privacy standards of this facility.

_____ _____
Patient or Guardian Date

_____ _____ _____
Relationship to Patient Witness Date