ALLERGY, ASTHMA
&
SINUS CENTER, L.L.C
7700 W VIRGINIA AVE., STE B
LAKEWOOD, CO 80226
PHONE (303) 238-0471
FAX (303) 238-6711

REQUEST FOR MEDICAL RECORDS

Patient Name:_____ **Date of Birth:**_____

I give consent for my medical information to be released.

TO:

ALLERGY, ASTHMA & SINUS CENTER, L.L.C

7700 W Virginia Ave., Ste B

Lakewood, CO 80226

FROM:

_____

_____

_____

PLEASE SEND THE FOLLOWING RECORD:

——— Skin Test Results ——— Serum Composition ——— Injection Schedule

——— Lung Function Results ——— Outpatient-Inpatient Records ——— All Records

——— Other: _____

PURPOSE FOR MEDICAL RECORDS:

——— Insurance ——— Transfer to another M.D. ——— Second Opinion

——— Other: _____

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 in writing 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 on longer protected by the privacy standards of this facility.

SIGNED: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____ **DATE:** _____

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SINUS CENTER, L.L.C
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CONSENT TO RELEASE MEDICAL RECORDS

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TO:

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FROM:

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7700 W Virginia Ave., Ste B

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