INTERMOUNTAIN Allergy & Asthma

12422 South 450 East, Suite C, Draper, UT 84020 (801) 553-1900 fax (801) 553-9995

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize: **Intermountain Allergy & Asthma of Draper**

To release to: _____

Address: _____

the following data from my medical records:

- ☐ Evaluation and treatment summary
- ☐ X-Ray report
- ☐ Actual skin test results (copy of testing sheet preferred)
- ☐ Actual formula of treatment extract and injection record
- ☐ Any other consultation reports
- ☐ All medical records on file
- ☐ Other (please specify) _____

PATIENT:

_____ _____ _____ _____
Last Name First Maiden Middle

_____ _____ _____ _____ (___)_____
Street Address City State Zip Phone

Birthdate _____ Approximate Dates Treated _____

Admitting Physician, (if hospitalized) _____

This is a single use authorization that expires upon completion of the request. This authorization may be revoked by sending a written request prior to the expiration event.

_____ _____
(Signature of Patient or Responsible Party) (Witness to Signature)

_____ _____
(Relationship to Patient) (Date)