

5929 S. Fashion Point Dr. Suite 101, South Ogden, UT 84403



(801) 476-0052

fax (801) 476-0064

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize:		rize:	Intermountain Allergy & Asthma of Ogden							
To rele	ease to:									
Addre	ss:									
the fo	llowing d	ata fron	n 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)									
PATIE	NT:									
	Last Name Street Address			First			Maiden	1 ()		Middle
				City		State	Zip	(/_	Pł	Phone
	Birthdate		Approximate Dates Treated							
	Admitt	ing Phys	sician, (if hospitalized)							
	_		norization that expires est prior to the expira			uest. Th	nis autho	rization n	nay be rev	oked by
(Signature of Patient or Responsible Party)					(Witness to Signature)					_
(Relationship to Patient)					(Date)					_