AUTHORIZATION FOR RELEASE OF INFORMATION

NAME OF PRACTICE: ALLERGY AFFILIATES, INC.

Patient Legal Name_____Birthdate_____

Address_____Telephone No._____

City_____State_____Zip Code_____

I hereby authorize to disclose medical records and/or protected health information of the patient listed above-

FROM:

Name and Organization_____

Address:_____

Fax:_____Telephone:_____

TO:

Name and Organization: Allergy Affiliates, Inc. John P. Cella, M.D.

Address: 5701 21st Avenue West, Bradenton, Fl. 34209

Fax: (941) 792-8463 Telephone: (941)792-4151

Please check items from the following list:

- ❑ H & P
- ❑ Lab
- ❑ Imaging/Radiology
- ❑ Demographics sheet
- ❑ Medication Record
- ❑ All Progress Notes
- ❑ Recent Progress Notes
- ❑ Entire Record
- ❑ Immunotherapy Extract
    - A. Specific Antigens
      *If mixes are used, please indicate the contents of the mix
    - B. Amount and concentration of each antigen incorporated into the vial.
    - C. Injection Records------date, dose, and concentration.
- ❑ Pulmonary Function Tests
- ❑ Skin Testing Results
- ❑ Other_____

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug, psychiatric or HIV information. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: 1) file a revocation form available from this office; or 2) write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I have read the above and authorize the disclosure of health information as stated.

_____ _____ _____

Date Signature of Patient/Parent/Patient Representative Relationship to Patient