

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 Allergy Affiliates, Inc. John P. Cella, M.D.

Address: 6220 Manatee Ave. W. Ste. 201 Bradenton Fl 34209

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

TO:

Name and Organization _____

Address: _____

Fax: _____ Telephone: _____

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