ALLERGY AND ASTHMA CENTER OF HILTON HEAD
25 Hospital Center Blvd, Suite 308
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 843-689-6158

Name: _____
DOB: _____
SSN: _____

I hereby authorize _____ to release my medical records and any other medical information necessary for the purpose of further healthcare or insurance needs.

I understand that I am responsible for its contents and am in no way holding the above responsible for disclosure of information revealed in the enclosed medical records.

_____ _____
(Patient Signature) (Date)

_____ _____
(Witness) (Date)

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The information below is being requested for internal use statistical purposes only. We would appreciate your completing the information, however, you are not obligated to do so.

Reason for Request: (Please check)

___ 2nd Opinion
___ Referral from Physician
___ Moving
___ Employer changing insurance to HMO/PPO
___ Insurance has requested
___ Other (please briefly explain) _____
_____
_____

TCB/ljsn
10/11