ALLERGY AND ASTHMA CENTER OF HILTON HEAD
60 Main Street, Suite D
Hilton Head Island, SC 29926
Phone: 843-689-6442 Fax: 888-397-1781

Patient Name: _____ Patient DOB: _____
Please PRINT

Chart # : _____

I hereby authorize _____ to release my medical records and any other medical information necessary for the purpose of further healthcare or insurance needs; to include all visit notes, procedures, lab and imaging results from _____ to _____.

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)

___ Referral from Physician
___ Moving
___ Other (please briefly explain)

_____

_____

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