

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

Name: _____
DOB: _____
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)

Please select which categories of your medical record you wish to have included:

- Demographic Sheet
- Insurance Information
- Visit/Encounter Notes
- Vital Signs record
- Imaging reports
- Lab results
- Skin Test results