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

Name: ______________________________

DOB: ______________________________

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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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
___ Shot records

Please send records to: ____ (there is a fee ($0.65 per page up to 31 pages) if being sent to an individual as opposed to a medical facility.)

Fax Number: ____

Email Address: ____