**AUTHORIZATION REQUEST FOR MEDICAL RECORDS**

I hereby authorize the release of my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary for treatment, health care operations or other purposes permitted/required by law.

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

From: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

City: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** State**: \_\_\_\_\_** Zip Code**: \_\_\_\_\_\_\_\_\_\_**

Please indicate the reason for this request:

\_\_\_\_\_\_ Copy for my personal record

\_\_\_\_\_\_ Consulting a new physician

\_\_\_\_\_\_ Transferring medical care to another allergist

\_\_\_\_\_\_ Moving out of the area

\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To: SUNSHINE ALLERGY**

**34041 U.S. Highway 19 North, Suite D**

**Palm Harbor, FL 34684**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Signature of Patient or Legal Guardian) (Relationship to Patient)*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Print Name of Patient or Legal Guardian) (Today’s Date)*