MEDICAL RECORDS RELEASE REQUEST FORM
Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:
Patient Name:
_____
Address: _____
_____
Phone: _____
SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically
describe) to disclose/release the following information* (check all applicable):
o All records
o Laboratory/pathology records
o X-ray/radiology records
o Billing records
o Abstract/Summary
o Pharmacy/prescription records
o Other (describe specifically)
*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis,
drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s):
Please send the records listed above to (use additional sheets if necessary):

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone _____
Fax: _____ Fax: _____

This authorization may not be valid for greater than one year from the date this form is signed. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit,or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, (i.e parent,guardian, power of attorney for healthcare, executor)
You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to Meher S. Khan MD 146 Montgomery Avenue Bala Cynwyd PA 19004

Meher S. Khan MD 146 Montgomery Avenue Bala Cynwyd PA 19004 (610)668-0836
Fax (610) 668-7922 www.allergymomMD.com