**CONSENT FOR RELEASE OF MEDICAL INFORMATION**

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Treatment dates: _____

I authorize: Sioux City Allergy & Asthma Associates, PC
4280 Sergeant Road, Suite 230
Sioux City, Iowa 51106
Phone: 712-274-6884

To release copies of my medical records to: _____

_____

_____

I authorize release of my medical information for the following reason(s):

____ Continuing Medical Care ____ Military ____Personal

____ Legal ____Or the following: _____

I authorize release of information of the following portions of my medical record:

____ Complete Medical Record ____ Office Notes/Dictation (Dates: _____)

____ Radiology ____ Labs ____ Other: _____

I understand that this information shall be in effect for 1 year following the date of signature; However, I understand that this authorization may be revoked at any time by giving written notice to the medical office. A photocopy of this authorization shall constitute a valid authorization. I understand that once my medical records have been released, the medical office cannot retrieve them and has no control over the use of the already released copies.

I hereby release Sioux City Allergy &Asthma Associates, PC from any and all liability which may arise as a result of my authorized release of records.

Should my case require review by a government agency or another medical profession actively involved in my care to make a final determination, it is with my consent that a copy of these records will be submitted to the agency or medical profession for this review.

Patient (Or Legal Representative): _____

Date: _____ Relationship to Patient: _____