ADVANCED ALLERGY
IMMUNOLOGY & ASTHMA P.C

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RECORDS RELEASE AUTHORIZATION

Date of Request:_____

Patient Name: _____
First Name MI Last Name

DOB: _____ Patient Phone Number:_____

Which M.D. do you primarily see in our office (**Please Circle One**):
Denis A. Bouboulis, M.D. Denise M. Kearney, M.D.

Signature: _____
MUST be signed by patient if patient is at least 18 years of age or older

Print Name: _____
By Signing above, this means that you are aware of the charges that are accompanied by your request, and that you agree to take responsibility for those charges. *

Relationship to Patient: _____

Records to be released: ☐ **Entire Medical Record** ☐ **Lab Results** ☐ **Doctor's Notes**
(Please Check One)

☐ **Specific Date(s) ____/ ____ /_____ - ____ /____ /____**

Reason for Record Release (*Please Check One*)
☐ Moving ☐ Requested by another Doctor ☐ Transferring Out of Practice ☐ Court Case

☐ Other: Please provide a brief explanation:_____

Release To(Name/Title):_____

Street Address:_____

City/Town:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____ Email:_____

*** Medical Record Prices (1-26pages @ .65ea/ 27-100 @ .50ea/ 100+ @ .25ea)**
** Please be aware that we have legally up to 30days to fulfill your record release.
***Attention Immunotherapy/Allergy patients receiving injections, please notify us if you will be leaving our practice, so we can transfer any existing vials, and immunotherapy schedules appropriately.