Authorization for Use and/or Disclosure of Confidential Information

Please ensure all information is complete and print legibly. "*" Indicates required fields

***Patient Name**: _____ ***Date of Birth**: _____
***Address:** _____
Telephone Number: _____ **Previous Name (if applicable)**: _____

-**This request will authorize**:

Allergy, Asthma & Immunology Associates, P.C.
2808 S 80th Ave. Ste. 210
Omaha, NE 68124
(P)402-391-1800 (F)402-391-1563

-To release records as indicated on this request

***Disclose To:** ***Receive From:** **(circle one)**

_____

_____

_____

_____

***The following information:**

- ○ Records from the last 1, 2, or 3 years (circle one)
- ○ Lab reports date(s):_____
- ○ Complete medical records
- ○ Other_____

***For the following purpose:**

_____

_____

_____

_____

_____
Signature of Patient or Legal Guardian
(Needed for minors: NE under age 19, IA under age 18)

_____
Relationship if not the patient

Date: _____

Office Use Only
Prepared by: _____ Date: _____
Date to send: _____
Date to pick up from AAIA: _____
Picked up on: _____
Released by: _____
Released to: _____

(rev. 09/2020)