



Allergy Asthma Care, P.C.

Allergy, Asthma, and Clinical Immunology

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I, _____, have been offered or received the Privacy Notice for Allergy Asthma Care, P.C. and signed the authorization for the following:

Please list below whom we can speak with and release information to:

(Please Understand a Medical Records release will need to be signed)

Family or Friend Name:	Relationship to the Patient:	Phone Number:	Leave Messages and Speak with:	Review Your Account with:	Ok to Pick up Prescriptions, Orders, and Medical Records:

I allow messages to be left on the telephone number I provided on the patient information form.

___ Yes ___ No

Signature _____

Date _____

Relationship to the Patient: _____

Refusal of Above: _____