IMPACT MEDICAL
Allergy, Asthma & Immunology

PRIMARY OFFICE
44 Route 23 North, Suite 6
Riverdale, NJ 07457
P: 973-248-9199 | F: 973-248-9299

Authorization for Release of Medical Records

Patient Name: ______________________________ **Date of Birth:** ______________________

Patient Address: ______________________________ **Contact Number:** __________________

AUTHORITY TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize Impact Medical - Allergy, Asthma & Immunology to release the information identified in the authorization form from the medical records of ________________________ and provide such information to:

Name: ________________________ Address: ____

Phone: __________________________________ Fax: __________________________________

INFORMATION TO BE RELEASED-COVERING THE PERIODS OF HEALTH CARE

From ______________________ to (date) _________________________ Entire Medical File

PURPOSE OF THE REQUESTED DISCLOSURE OF PROTECTED HEALTH INFORMATION

I am authorizing the release of my Protected Health Information for the following purposes (e.g. a purpose may be "at the request of the individual"):

Signature: ____ Date: ___________________

Relation to the patient: ____

PLEASE NOTE: PLEASE ALLOW 24-48 HOURS FOR YOUR REQUEST TO BE COMPLETED