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:** _____

Email Address: _____

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: _____