

ADVANCED ALLERGY & ASTHMA CARE  
430 W. CENTRE AVE.  
PORTAGE, MI 49024  
(269) 321-6673  
(269)324-5594 FAX

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**  
*The below is to ensure your right to privacy. Please complete in its entirety.*

I, authorize \_\_\_\_\_ to release the following  
medical information regarding \_\_\_\_\_ DOB: \_\_\_\_\_  
(Patient's name on record)

Patient's Social Security # \_\_\_\_\_ to:

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(Please initial appropriate line)

\_\_\_\_\_ Any and all of patient's medical records (as of this date) – OR –  
\_\_\_\_\_ Send specific records as listed below:

\_\_\_\_\_  
\_\_\_\_\_

This information is being released for the following purpose(s) only: \_\_\_\_\_  
\_\_\_\_\_ and may not be used for any other  
purpose or released to any other person(s) without my written consent.

This release is effective for one (1) year from the date of execution; however,  
it may be revoked by me at any time by providing notice in writing to the  
above named party.

S/ \_\_\_\_\_ Phone #: \_\_\_\_\_  
Patient/Legal Guardian of Patient

S/ \_\_\_\_\_ Date: \_\_\_\_\_  
Witness

**FOR OFFICE USE ONLY:**

Date sent/received: \_\_\_\_\_

Mode used: \_\_\_\_\_

By whom: \_\_\_\_\_