ALLERGY & ASTHMA SPECIALISTS, P.C.

www.Allergy-Asthma.net

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Patient Name_____
Pickup_____Mail_____ (check one)

( ) I request that Allergy & Asthma Specialists **release** a copy of my medical records to:

_____

Please specify whole record or portion required _____

( ) I request a copy of my medical record from your office **be sent to: Allergy & Asthma Specialists.** Check one _____Chelmsford _____Nashua _____N. Andover.

Name of Physician/Facility _____

Address_____

Please specify whole record or portion required_____

Patient Name_____DOB_____

Patient address _____

Patient/parent or guardian signature _____Date_____

Witness_____Date_____

Please note:

If you have tested for HIV, these results will not be included in the copy of your records unless a special request and authorization is obtained. This office can only release records that are our original records. We cannot release records that have been transferred here from another physician/facility. As required under HIPAA minimum necessary rule for medical records, we will request or send only the minimum necessary information. (In some instances this may be the complete medical record)

I have tested for HIV and request that these results be included with my medical record release request:_____
(Patient Signature)

This section below is optional but it will help us to better serve our patient population.

Reason for requesting records:

Receiving medical care elsewhere _____I am leaving the geographic area _____

I am dissatisfied with **AAS.** Please note reason_____

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