ALLERGY AND ASTHMA INSTITUTE OF JOHNS CREEK

10700 Medlock Bridge Road
Suite 102
Duluth, GA 30097
Phone: (678) 615-7878

LAST NAME:	**FIRST NAME:**	**BIRTH DATE:**
ADDRESS 1:		
ADDRESS 2:		
CITY:	**STATE:**	**ZIP CODE:**

I permit (list facility name)

_____

to disclose/release the following information (check all applicable):

☐ ALL MEDICAL RECORDS

☐ All medical progress notes from visits within the past 12 months

☐ Laboratory/pathology records

☐ X-ray/radiology reports

Please fax the records listed above to our office at (770) 685-1241.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient/Guardian Signature:_____ Date _____

Printed Name of Guardian:_____