Candice M. Rohr, M.D.
Alice H. Chou, M.D.
Alalia W. Berry, M.D.

330 S. Garden Way #150
Eugene, OR 97401
(541) 485-0316
(541) 431-0317 FAX

330-C NW Elks Dr.
Corvallis, OR 97330
(541) 754-7170
541) 758-0707 FAX

ALLERGY AND ASTHMA CENTER, P.C.
MEDICAL RECORDS REQUEST

This authorization must be written, dated, and signed by the patient or by a person authorized by law to give this authorization

I authorize information to be released:
FROM:_____
_____
_____
FAX:

Please send my records:
TO:_____
_____
_____
FAX:

PURPOSE OF THIS RELEASE: (please circle one)

Medical care *Change of PCP* *Relocating* *Legal* *Billing* *Other*_____

TYPE OF INFORMATION TO BE RELEASED:

_____*All Medical Records (records released will be limited to the last two years of information unless otherwise indicated)*

_____*Physician Notes/Spirometry*

_____*Skin Tests/Antigen Recipes*

_____*Lab and/or Pathology Reports*

_____*X-ray/CT reports*

_____*Hospital Records/Consultations*

_____*Worker's Comp Injury Records*

**Must be in initialed to be included in other documents*

_____**HIV/AIDS-related records*

_____**Mental Health Counseling and/or treatment program information*

_____**Genetic Testing information*

_____**Drug/alcohol diagnosis, treatment, or referral information (Federal regulation 42 CFR Part 2, requires a description of how much and what kind of information is disclosed)*

_____*Other*_____

Initial and Complete if applicable:

_____*This authorization is limited to the following time period:*_____

_____*This authorization is limited to the following treatment:*_____

PATIENT AUTHORIZATION TO RELEASE INFORMATION:

_____
Patient Name(please print) *Date of Birth* *Phone Number*

_____
Address *City* *State* *Zip Code*

_____
Signature of patient or legally responsible person *Relationship to patient* *Date*

I specifically give authorization to fax my medical information. I understand that risk is involved in faxing records and confidentially at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information
_____Initials

This authorization is valid until patient's death and may be revoked by the patient orally or in writing at any time. The exception is when the action has already occurred as instructed in this consent.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

2019