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**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>I authorize information to be released:</i> FROM: _____ _____ _____	<i>Please send my records:</i> TO: _____ _____ _____
FAX: _____	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

*Must be in initialed to be included in other documents

____ Skin Tests/Antigen Recipes

____ *HIV/AIDS-related records

____ Lab and/or Pathology Reports

____ *Mental Health Counseling and/or treatment program information

____ X-ray/CT reports

____ Hospital Records/Consultations

____ *Genetic Testing information

____ Worker's Comp Injury Records

____ *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.