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: _____

****PLEASE MAIL IF MORE THAN 30 PAGES****

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

_____Other_____

**Must be 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)*

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 confidentiality at the receiving end cannot always be guaranteed. All faxed information will contain a confidentiality statement and instructions for returning misdirected information **_____**INITIALS**

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.

If we, the healthcare provider, are requesting this Authorization from you for our own use and disclosure or to allow another healthcare provider or health plan to disclose information to us: 1) We cannot condition our provision of services or treatment to you on the receipt of this signed authorization; 2) You may inspect a copy of the protected health information to be used or disclosed; 3) You may refuse to sign this Authorization; and, 4) We must provide you with a copy of the signed Authorization.

THIS AUTHORIZATION IS VALID UNTIL THE PATIENT'S DEATH.

You have the right to revoke this Authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this Authorization or to the extent you signed this Authorization as a condition to insurance coverage. To revoke this Authorization, please contact our Privacy Officer.