Asthma & Allergy Physicians of RI, I n c.
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MEDICAL RECORD RELEASE FORM

Telephone: 401-751-1235
Fax: 401-751-4744

_____ _____
Patient Name Date of Birth

I hereby authorize AAPRI to release medical information to:

_____

Name:_____ Telephone:_____

Address:_____ Fax:_____

_____

_____

Relationship to Patient: _____

_____

Medical Information Requested:

□ All Records

□ Specific Records from_____to_____

□ Allergy tests, allergy injections, SLIT drops

□ Labs

Reason for request:

□ 2nd Opinion

□ Referral from Physicians

□ Moving

□ Employer changing insurance, which we are not affiliated

□ Insurance has requested

□ Other:_____

_____ _____
Signature of Patient or Legal Guardian Date

This release authorizes the disclosure of records indefinitely from the date signed above or until we receive written notice from you requesting to revoke this agreement. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for Asthma, Allergy & Immunology. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Medical Records Release Fee: $15
10 cents per page over 100 pages
Add'l: mailing fee if appropriate

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