

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

DATE: _____

ATTENTION: _____

PHONE: _____ FAX: _____

You are hereby authorized to release my medical records/x-rays/lab reports to:

TRAVIS A MILLER, MD
1478 STONE POINT DR., STE 290
ROSEVILLE, CA 95661

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

- Skin Tests
- Shot record
- Antigen Formula
- Clinical Notes
- Spirometry/PFT
- Radiology
- Labs
- Hospital/Discharge notes
- Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy regulations in accordance with 45 CFR.

Signature of Patient or Legal Representative

Legal Representative's Relationship to Patient