Authorization for Release of Medical Records

Advanced Allergy & Asthma
500 South University, Suite 215
501-420-1085 Phone

Dr. Melissa Graham & Associates
Little Rock, Arkansas 72205
501-420-1457 Fax

I hereby authorize **Advanced Allergy & Asthma** to release medical records and data pertaining to:

Patient Name	Date of Birth
Mailing Address	City/State/Zip
Home Phone	Work Phone
Cell Phone	Insurance Provider
Member ID#	Group #

Purpose of Disclosure____

The authorization will expire on ______________________________ *(Date or Event may not exceed one year.)*

Please release the records of the above named patient to:

Doctor or Clinic:		
Mailing Address		
City:	State:	Zip:
Phone:	Fax:	

NAME: MELISSA GRAHAM, M. D.	BUSINESS: ADVANCED ALLERGY & ASTHMA
STREET: 500 SOUTH UNIVERSITY, SUITE 215	CITY/ST/ZIP: LITTLE ROCK, AR 72205
PHONE NUMBER: 501-420-1085	FAX NUMBER: 501-420-1457

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above named office may not condition treatment on my signing of this authorization.

Signature of Authorized Representative________________________________ Date____________

Relationship to Patient____

Internal use only:
Date Medical Records Request Received from patient:______________________________

Date Records Faxed or Mailed:______________________________