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 the release of 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 #**

Name of Provider to release information _____

Purpose of Disclosure_____

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

Specific items requested:

_____

_____

_____

_____

Method of release: Fax to 501-420-1457

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 Received from patient_____ **Date faxed** _____

Date records received by courier_____ **Date records received by fax**_____