

ALLERGY & ASTHMA SPECIALISTS, P.C.

www.Allergy-Asthma.net

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Patient Name _____

Pick Up Mail Fax

() I request that Allergy & Asthma Specialists, P.C. **release** a copy of my medical records to:

() I request a copy of my medical record from your office **be sent to Allergy & Asthma Specialist, P.C.** Chelmsford Nashua North Andover

Name of Physician/Facility _____

Address _____

Please specify whole record or portion required _____

Patient Name _____ DOB _____

Patient Address _____

Patient/Parent or Guardian Signature _____ Date _____

Witness _____ Date _____

Please note:

If you have tested for HIV, the results will not be included in the copy of your records unless a special request and authorization is obtained. This office can only release records that are our original records. We cannot release records that have been transferred here from another physician/facility. As required under HIPAA minimum necessary rule for medical records, we will request or send only the minimum necessary information. (In some instances this may be the complete medical record)

I have tested for HIV and request that these results be included with my medical records release request: _____

(Patient Signature)

This section below is optional but it will help us to better serve our patient population.

Reason for requesting records:

Receiving medical care elsewhere _____ I am leaving the geographical area _____

I am dissatisfied with AAS. Please note reason _____

HIPAARecordRelease 12/14

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200 SUTTON STREET ♦ SUITE 150
NORTH ANDOVER, MA 01845
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