

AAPRI
Asthma & Allergy
PHYSICIANS OF RHODE ISLAND

JOHN ZWETCHKENBAUM, MD
VIKRAM MALIK, MD
TEL#401-751-1235 FAX#401-751-4744

MEDICAL RECORD RELEASE FORM

Patient Name

Date of Birth

I hereby authorize AAPRI to release my medical information to:

Name: _____ Telephone: _____

Address: _____ Fax: _____

Relationship to Patient: _____

Medical Information Requested:

- All records
- Specific Records from _____ to _____
- Allergy test, allergy injections, SLIT drops
- Labs
- Employer changing insurance which AAPRI is not affiliated

Reason for request:

- 2nd Opinion
- Referral from Physician
- Moving
- Other: _____
- Insurance has requested

Signature of Patient or Legal Guardian

Date

- *Medical Records Release Fee \$15.00
- *10 cents per page over 100 pages
- *Additional mailing fee if appropriate

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.