KERN ALLERGY MEDICAL CLINIC, INC.
Tonny Tanus, M.D. Eric J. Boren, M.D.
1921 18th Street Bakersfield, CA 93301
(661) 327-9693 Fax (661) 327-0749

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below. Failure to provide all information requested may invalidate this Authorization. I hereby authorize _____ _____ to use and disclose a copy of the specified health and medical information identified below to _____ _____ _____

Patient Name | Date of Birth | Social Security Number

To the following persons/organization

1) Kern Allergy Medical Clinic, Inc.
   2121 17th St.
   Bakersfield, CA 93301

2. _____
   _____
   _____

For the following purposes Check (X) which applies

_____ Medical Care
_____ Attorney Use
_____ Personal use
_____ To obtain additional benefits
_____ Payment of a claim
_____ Other _____

I specifically authorize the use and/or disclosure of the following health information and/or medical records to the extent such information and/or medical records exist.

Type of Information	(X) which apply	Type of Information	(X) which apply
Allergy testing		Physicians Notes	
Billing Records		Radiology Reports	
Laboratory Reports		Pulmonary Function Test	

For records to be sent out, I understand access to my health information will be given. Exceptions to this occur rarely, such as when the information is deemed dangerous. If access is denied, an explanation will be provided. If I contest this denial, a third party will review the situation.

This Authorization will expire 180 days from the date I sign it as evidenced below or until _____ (insert applicable date or event). I may revoke this authorization at any time, provided that I do so in writing and deliver the revocation to Kern Allergy Medical Clinic, Inc., 2121 17th Street, Bakersfield, CA 93301. My revocation will be effective upon receipt, and I know that previously disclosed information will not be subject to my revocation.

For letters and forms to be filled out and any records to be sent out from Dr. Tanus/Dr. Boren's office, I am responsible for the cost of medical records disclosure. Sometimes courtesy (no fee) is given if the records are requested by and to be sent to another doctor's office.

The cost to be paid in advance is _____. Cash or check is attached or credit cared to be billed is Visa _____ Master Card _____ or American express _____ Card Number _____ Exp date _____

I understand that if I have authorized the disclosure of information to a person or entity that is not legally required to keep it confidential the information may be re-disclosed and may no longer be protected. Therefore I release Kern Allergy Medical Clinic, Inc. and its employees from liability and all legal responsibility arising from this disclosure of health information.

Date: _____ Signature: _____
Patient/Legal representative

If signed by someone other than the patient, state your legal relationship to the patient _____

Witness/Money received by: _____