



Tonny Tanus, M.D • Eric J. Boren, M.D

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Requesting records from: _____ or Send records to: _____

Patient Name: _____ DOB: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal/claim and or continued medical care. I expressly request that the designated record custodian of all covered entities under HPPA identified about disclose full and complete protected medical information including the following:

Type of information being requested			
Please (X) which apply	Approx. Date(s)	Please (X) which apply	Approx. Date(s)
Allergy testing		Radiology Reports (CXR, CT Scan, MRI, other)	
Laboratory Report(s)		Pulmonary Function Test(s)	
Endoscopy Reports(s)		Urgent Care/Emergency Room Report(s)	
OTHER:		Clinical Notes	
If other please specify:			

Release protected health information to the following persons/organization:

**1429 Main Street
 Delano, CA 93215
 Tel: (661) 721-8832 Fax: (661) 721-8319
allergykern@gmail.com**

For the following purposes please (X) which applies:

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

This Authorization will expire 180 days from the date I sign it as evidenced below or until I may revoke this authorization at any time, provided that I do so in writing and deliver the revocation to Kern Allergy Medical Clinic. My revocation will be effective upon receipt, and I know that previously disclosed information will not be subject to my revocation.

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: _____

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

Office USE Only:	
Office Staff/Money received by: _____	Amount Paid/fee: _____