Tonny Tanus, M.D • Eric 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:
Kern Allergy Medical Clinic
443 W. Morton Ave Ste A
Porterville CA, 93257
Tel: (559) 782-8578 Fax: (559) 782-8594
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, Inc., 1921 18th 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.
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: _____