Bay Shore Allergy & Asthma Specialty Practice, PC
Asthma, Allergy, Clinical Immunology & Pediatric Pulmonary Specialist
649 Montauk Highway
West Bay Shore, NY 11706
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AUTHORIZATION FOR RELEASE OF MEDICAL AND HEALTH CARE INFORMATION (HIPAA COMPLIANT)

_____
(Patient's Name)

Date of Birth _____ SS#_____

1) _____ For Bay Shore Allergy Group to release records to:

_____

_____
(Healthcare provider address and phone#)

2) _____ Patient requests copy of their medical records for personal use.

3) _____To release the following information to:

BAY SHORE ALLERGY GROUP 649 Montauk Hwy., West Bay Shore, NY 11706

_____Lab Tests _____Radiology Reports _____Consultations _____Entire Record
_____Other (explain) _____

THIS AUTHORIZATION REFERS TO INFORMATION DATED FROM _____TO_____

ATTENTION PATIENT: **If the following information pertains to your medical history, please initial the space that pertains to your records.** YOUR INITIALS INDICATE PERMISSION FOR YOUR HEALTHCARE PROVIDER TO RELEASE SPECIFIC CONFIDENTIAL RECORDS TO BAY SHORE ALLERGY GROUP.

The patient's medical records are being requested for the purpose of enhancing medical care. This authorization is valid for 120 days from the date of signature. The patient can revoke this authorization at any time of notifying Bay Shore Allergy Group in writing. The patient agrees that a copy of this authorization may be considered valid authorization.

I understand that the practice will charge me ($.75 per page for copying fees. If I am granted access to the requested information, I (please check the appropriate boxes) ( ) would ( ) would not like the practice to provide me with an additional written ( ) summary ( ) explanation of such requested information at an additional cost to me of **($100.00)**.

Patient's Signature: _____ **Date** _____