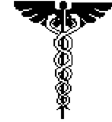
ADVANCED ALLERGY & ASTHMA CARE, PLLC
6233 66TH STREET NORTH, PINELLAS PARK, FL 33781
www.allergydoc.us



Send records to:

PH. (727) 544-8100 FAX: (727) 544-8200

☐ **DR. LATHA CHAMARTHY, MD**

☐ **DR. MADHURIMA SANKA, DO**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORDS

This authorization to receive or release information is being requested of you to comply with HIPAA.

PATIENT'S NAME: ______________________________

BIRTH DATE:______________________

CELL:.______________________

I HEREBY AUTHORIZE:

NAME OF THE PERSON OR ORGANIZATION RELEASING

INFORMATION:______________________________

STREET ADDRESS:______________________________

CITY:______________________STATE:______________________ZIP:______________

PHONE:______________________ FAX:______________________

TO RELEASE INFORMATION TO:

ADVANCED ALLERGY & ASTHMA CARE, PLLC
6233 66TH STREET NORTH
PINELLAS PARK FL 33781
VIA FAX:727-544-8200

THIS RELEASE LIMITS DISCLOSURE TO: ☐ ALL RECORDS (OR)

☐ LAB ☐ X-RAYS /CT SCANS ☐ IMMUNIZATIONS ☐ SKIN TEST RESULTS ☐ PATCH TEST

☐ SPIROMETRY ☐ SKIN BIOPSY ☐ OV NOTES______________________

☐ OTHER______________________________

A SPECIFIC AUTHORIZATION IS REQUIRED TO RELEASE INFORMATION REGARDING THE FOLLOWING(PLEASE INITIAL THE COLUMNS IF THIS INFORMATION IS TO BE INCLUDED)

	YES	NO	INITIALS
HIV INFORMATION			
DRUG/ALCOHOL INFORMATION			
MENTAL HEALTH INFORMATION			

THIS INFORMATION IS REQUIRED FOR:

☐ CONTINUITY OF CARE

PARENT/ GUARDIAN/ AUTHORIZED REPRESENTATIVE'S SIGNATURE:______________________________