AIANE Allergy & Immunology Associates of New England

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REQUEST FOR RELEASE OF MEDICAL RECORDS:

FROM DOCTOR:_____
ADDRESS:_____
_____

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE SENT TO:

DOCTOR:_____
ADDRESS:_____
_____

PATIENTS NAME:_____ D.O.B_____
PATIENTS SIGNATURE:_____
PARENT OR LEGAL GUARDIAN (FOR MINORS)_____

THIS MEDICAL RECORD MAY CONTAIN INFORMATION CONCERNING HIV TESTING AND/OR AIDS DIAGNOSIS OR TREATMENT. SEPARATE CONSENT MUST BE GIVEN TO HAVE THIS INFORMATION DISCLOSED.

I DO / DO NOT (CIRCLE ONE) CONSENT TO HAVE HIV/AIDS INFORMATION DISCLOSED:
DATE:_____SIGNATURE:_____

THIS MEDICAL RECORD MAY CONTAIN INFORMATION ABOUT DRUG ABUSE, ALCOHOLISM, ALCOHOL ABUSE, VENEREAL DISEASE, ABORTION OR MENTAL HEALTH TREATMENT. SEPARATE CONSENT MUST BE GIVEN BEFORE THIS INFORMATION CAN BE RELEASED.

I DO / DO NOT (CIRCLE ONE) CONSENT TO HAVE THE ABOVE INFORMATION DISCLOSED:
DATE:_____SIGNATURE:_____

IF YOU HAVE AN UPCOMING APPOINTMENT WITH THE DOCTOR WE ARE SENDING RECORDS TO PLEASE LIST DATE _____
ARE YOU LEAVING THE PRACTICE: YES / NO (CIRCLE ONE)