ADULT & PEDIATRIC ALLERGY ASSOCIATES, P.C.
FADIA HABIB-KHAZEN, M.D.,F.A.A.P., F.A.C.A.A.I.
Housam Alasaly, M.D.
DIPLOMATES AMERICAN BOARD OF ALLERGY & IMMUNOLOGY

AUTHORIZATION TO RELEASE RECORDS

Patient Name: _____

Date of Birth: _____

Address: _____

I hereby authorize the release of medical records:

To / From: **Adult & Pediatric Allergy Associates**
2236 W. Bethany Home Road
Phoenix, AZ 85015
Ph 602-242-4592
Fax 602-242-9220

From / To: _____
_____
_____
_____

Please following records requested / as requested:

Date of Service: _____

- ☐ **All pertinent information**
- ☐ **Consultation Report**
- ☐ **History and Physical**
- ☐ **Lab Reports**
- ☐ **Medical Records**
- ☐ **Radiology Reports**
- ☐ **Other :_____**
- ☐ **X-Ray Reports**
- ☐ **Sinus CT Reports**
- ☐ **Pathology Reports**
- ☐ **Echocardiogram Report**
- ☐ **Pathology Report**
- ☐ **Most Recent MD Notes**

I, the undersigned hereby authorized the identified above to provide a copy of any and all medical records related to the care or services provided. This request shall include HIV, drug and alcohol use and mental health records.

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice. I understand I cannot revoke this authorization retroactively for any information already received.

I hereby release you, your physicians, and your employees from any and all liability for fulfilling the authorized request for release of medical information. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original.

Signature _____ Date _____

Note: The information requested/included is *confidential* and intended for the parties listed here only. Should you have received this information in error, please discard, disregard and notify the sender immediately. Thank you.

Revised 5/2013