Bernstein Allergy Group, Inc.

4665 E Galbraith Road, 2nd Floor, Cincinnati, OH 45236
11005 Montgomery Road, 2nd Floor, Cincinnati, OH 45249
Telephone: 513-931-0775 **Fax:** 513-931-0779

Authorization to Release Medical Records

Patient Information

Patient Name: ______________________________ **DOB:** ____/_____/_____

Address: ______________________________

City: ______________ **State:** ______ **Zip:** __________ **Phone:** ______________

I, ______________________, authorize Bernstein Allergy Group, Inc. to use or disclose the protected health information listed below. Please specify the type of information, including dates of treatment, that you want to be disclosed.

Information to Release: ______________________________

____

Release Records To:

Facility: ______________________________

Address: ______________________________

City: ______________ **State:** __________ **Zip:** ______________

Phone: ______________________ **Fax:** ______________________

This authorization will expire six months after the date below or on: ______________

I understand that I have the right to revoke this authroization in writing, at any time by sending notice to Bernstein Allergy Group, Inc. In order to revoke the authorization, the written notice must be signed by the individual/parent/guardian. I also understand that the revocation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

I understand that information used or disclosed because of this authorization may be subject to redisclosure by the receipient and may no longer be protected by federal or state law. I understand that a standardized fee has been established for copies of medical records. Please inquire regarding these fees prior to requesting copies.

Please state reason for leaving our practice (if applicable):

____

Signature: ______________________________ Date: ______________

I am a: ___Patient ___Parent ___Legal Guardian