Carolina Asthma & Allergy Center
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Request for Access to Protected Health Information

I request the release of the health information of:

Patient Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Cellphone: _____

Release Information From		Release Information To	
Carolina Asthma and Allergy Center			
(List applicable Facilities and or Practices)		(Name of Facility, Person, Company)	
(Address)		(Street Address or PO Box, City, State, Zip Code)	
(Phone Number) (704) 372-7900	(Fax Number)	(Phone Number)	(Fax Number)

Purpose of Release (check reason): ❑Request of individual/personal ❑ Continued patient care ❑ Insurance
❑ Legal purposes including discussions and proceedings ❑ Other

Dates of Treatment for records to be released: From _____ To _____

Specialist's Summary Information to be released:

❑ Entire Record _____
❑ Consultation Report _____
❑ Treatment for alcohol and/or drug abuse _____
❑ Skin Test Results _____
❑ FeNO _____
❑ Progress Notes _____
❑ Laboratory Tests/Results _____
❑ Radiology (CT & X-Ray) _____
❑ Spirometry _____
❑ History and Physical _____
❑ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
❑ Other (please specify) _____

Format:

❑ Paper Copy ❑ Electronic Copy

Delivery Method:

❑U.S. Mail ❑Pickup ❑Fax, where permitted

I understand that I *may be charged a fee* for:

- Preparation of Summary or explanation of my protected health information.
- Reproduction costs of my protected health information or a copy of the summary for explanation.
- Mailing costs.

Signature of Patient's Representative _____ Date _____

Print Name _____

Relationship of Representative to Patient **(Please describe Representative's authority to act on behalf of the Patient)**