Neetu Talreja, M.D. Charles N. Webb, M.D. Jeremy Waldram, M.D.
Brianne Ayers, PA-C Kinsley Bonfilio, PA-C Courtney Flynn, NP
Board Certified in Pediatrics and Adult Allergy, Asthma & Immunology
Clinic locations in Boise, Meridian, Nampa, Eagle and Caldwell
Website: www.theallergygroup.com
Email: info@theallergygroup.com
Phone: 208.377.4000 Fax: 208.375.8426

AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT NAME: ____________________________________ Maiden/Other name: _________________

DATE OF BIRTH: __________________________ SSN: ____

Patient Records **FROM:** ____
Physician/Medical Office

____
Address State

____
State Zip Phone/Fax

I hereby authorize and request the release of the following information:
___ All Patient Information
___ Patient Information for visit date(s) of ______________to_____________
___ All Billing Statement
___Other (specify): ____

PLEASE SEND MY RECORDS TO: The Allergy Group
1000 N. Curtis Road Suite 303
Boise, ID 83706
Phone (208)377-4000
Fax (208)375-8426

Purpose for release of information:

____

Upon request, you may limit the amount of time that this consent for release of information is valid. You may revoke his authorization and writing at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign authorization and note that I do not need to sign for shot treatment. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure by the recipient. Photocopies or facsimile of this authorization shall be considered in agreement like the original document.

Signature: ____ Date: _______________________

Relationship to patient (If parent of guardian) ____

Office Use Only Released:
Date______________________ To: ____ By:____________________________