Gina Dapul-Hidalgo, MD
Family Center for Allergy and Asthma

Authorization for Release of Medical Information

Name of Patient _____ Date of Birth _____

_____
Address (including City, State and Zip Code)

_____
Phone Number

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

Information to be released or accessed:

☐ Complete Records	☐ Lab Reports	☐ Progress Notes
☐ Care Plan	☐ Treatment Record	☐ Radiology
☐ History & Physical	☐ Medication Record	☐ Other: _____

These records are for services provided for the following date(s): _____

Reason for disclosure:

☐ At my request ☐ Continuation of medical care ☐Payment/Insurance ☐ Other: _____

INFORMATION RELEASE TO:

Family Center for Allergy and Asthma
Name of Facility

15200 Shady Grove Road, Suite 400 Rockville, MD 20850
Address (including City, State and Zip Code)

240-243-6115	240-437-0277	info@dapulallergy.com
Phone Number	Fax Number	Email (HIPAA Compliant)

FROM:

_____
Name of Facility

_____
Address (including City, State and Zip Code)

_____
Phone Number Fax Number

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

This authorization will expire in six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature of Patient or Legally Authorized Representative

Date

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient