ALLERGY & ASTHMA CONSULTANTS, LTD.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: (If 18 or older) ______________________

I request and authorize ____ to release healthcare information of the patient named above to:

Name: **Allergy & Asthma Consultants, Ltd.**

Address: **36100 N Brookside Drive, Suite # 203**

City: **Gurnee** State: **IL** Zip Code: **60031**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

X______________________________ **Relation to patient?:** SELF / PARENT / LEGAL GUARDIAN

(PRINT YOUR NAME CLEARLY)

Patient/Guardian Signature: **X** ______________________ **Date Signed:** **X** ______________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.