ASTHMA, ALLERGY & IMMUNOLOGY INSTITUTE, PLC
29275 Northwestern Highway, Suite 202
Southfield, Michigan 48034.
Telephone (248) 304-8904; Fax: (248)304-8906

Consent to Release Medical Information or Records

I hereby authorize:

_____

_____

Release my medical records to:

Asthma, Allergy & Immunology Institute, PLC
29275 Northwestern Highway, Suite 202
Southfield, Michigan 48034
Telephone (248) 304-8904
Fax (248) 304-8906

_____ _____ _____
Patient's name (print) **Birthdate** **Social Security Number**

Patient Address _____

Daytime Telephone Number _____

Write your initials _____ Disclosure is authorized for any and all information about medical history, mental and physical condition, including HIV Infection, AIDS, or ARCD, drug and alcohol use, and other personal information.

Write your initials:_____ Disclosure is authorized for the following specific report(s)/information only: _____

_____

This authorization is valid for six (6) months from the date of signing unless revoked in writing by the undersigned prior to six (6) months.

_____ _____
Patient, Parent of a Minor Patient, or Legal Guardian Signature **Date**

_____
Printed Name of Patient, Parent of a Minor Patient, or Legal Guardian