Asthma & Allergy Clinic of Marin and San Francisco Inc.
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1000 South Eliseo Dr. #10, Greenbrae, CA 94904
Ph# (415) 461-8909; Fax# (415) 461-1660

6850 Geary Blvd, San Francisco, CA 94121
Ph# (415) 751-6800; Fax# (415)751-6808

Consent Authorization for Release of Medical Information

I _____ hereby authorize *Asthma and Allergy Clinic of Marin & San Francisco Inc.* to release medical records information regarding the following patient:

Patient's Name: _____ **Date of Birth:** _____

Send To: _____

Mailing Address: _____

_____

Or Fax To: _____

Such disclosure shall be limited to the following medical records, specific type of information, or dates of treatment:

_____ Complete Medical Record

_____Progress Notes ____Skin Testing _____Pulmonary Function Test

_____Lab Result _____CXR / CT Sinus / MRI ____Allergy Shot Record

_____ Antigen Formula ____ Other:

I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

I agree to pay any fee associated in copying the above records(check below for applicable fees)

Date: _____ **Signature:** _____ _____

If signed by other than patient, indicate relationship

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Please allow 3 working days to process this request.

Applicable Fees	Fee for Clerical & Copying
Patient or Physician Office (Initial copy)	No Fee
Additional copy of records	$15
Insurance Company	$25

Total Charge $ _____ Paid by: __ Cash / __Check # _____ / __MC or VS Received by _____ Date _____

Warning: This fax contains confidential medical information.

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