the allergy station
Travis A Miller MD

phone/fax: (916) 238.6238
1478 Eureka Road Suite 290
Roseville CA 95661
theallergystation.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

DATE: _____

ATTENTION: _____

_____

_____

PHONE: _____ FAX: _____

You are hereby authorized to release my medical records/x-rays/lab reports to:

TRAVIS A MILLER, MD
1478 EUREKA RD STE 290
ROSEVILLE, CA 95661

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

_____

Skin Tests
Shot record
Antigen Formula
Clinical Notes
Spirometry/PFT
Radiology
Labs
Hospital/Discharge notes
Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire in 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy regulations in accordance with 45 CFR.

_____ _____

Signature of Patient or Legal Representative

Legal Representative's Relationship to Patient