

REQUEST FOR RELEASE OF RECORDS

Patient: _____

Date of Birth: _____

SSN: XXX-XX-__ __ __

Medical Record Number: _____

From DOCTOR(s) or HOSPITAL(s):

Date faxed

_____ fax: _____

_____ fax: _____

_____ fax: _____

_____ fax: _____

Effectively immediately, I hereby authorize and request you to release by mail or facsimile to:

Jeremy E. Kaslow, M.D., F.A.C.P., F.A.C.A.A.I.
720 North Tustin Avenue Suite 206
Santa Ana, CA 92705-3606
714-565-1032 FAX 714-565-1035

- All medical records concerning any aspect of my medical care from
- Only laboratory, biopsy, radiograph, spirometric or other test reports from
- Only skin test results and allergy extract formulas from
 - the beginning of my illness or my first visit with you or your group.
 - _____.

The medical records requested are to only to be used for medical care. They will not be released to another party without specific written authorization. A photocopy or facsimile of this request shall be as valid as the original and remain in effect for 12 months from the date of signature below. I may revoke this authorization in writing effective at any time. My next appointment with Dr. Kaslow is _____. Thank you for your cooperation and rapid response.

Signed: _____ /Witness: _____

Date: _____

PROHIBITION OF RE-DISCLOSURE and CONFIDENTIALITY NOTE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations prohibit you making any further disclosure without the specific written consent of the persons to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical information is NOT sufficient for this purpose.

The information released is intended only for the use of the individual(s) or entity(s) listed above and is confidential and legally privileged.