CAAC
Connecticut Asthma & Allergy Center

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I/We authorize and request that_____release copies of:
(Name of Doctor/Business to release)

❒ Office visit reports
❒ Office visit notes
❒ Allergy skin tests
❒ Allergy shot records
❒ Pulmonary functions
❒ X-rays/CT scans
❒ Laboratory results
❒ Prescription records
❒ EKGs
❒ Tympanograms
❒ Methacholine Challenges
❒ Exercise Challenges
❒ Food Challenges
❒ Other:_____
❒ All the above

and I understand the information released may include Psychiatric/Drug/Alcohol/HIV/AIDS information from the medical record of:

_____
(Patient's First and Last Name)

Please forward to: Name:_____

Address:_____

_____

_____

Phone Number: (_____) _____-_____

Patient Signature:_____ Date:_____/_____/_____

Patient Address:_____

_____

Patient Phone #: (_____) _____-_____ Patient Date of Birth:__/_____/_____

If patient is a minor child, please complete both parents' signatures
(or guardian signature) below.

_____(Mother) Date:_____/_____/_____

_____(Father) Date:_____/_____/_____

_____(Legal guardian) Date:_____/_____/_____
(Proof of guardianship must be submitted with request.)

The confidentiality of this record is protected by the Federal Confidentiality Regulations 42 CFR 9 part 2 and chapter 899c of the Connecticut General Statues. This information shall not be transmitted to anyone else without written consent or other Authorization as provided in the statutes. I may revoke this authorization at any time, except to the extent that action has been taken in reliance upon it.