RVA ALLERGY

MEDICAL RECORDS RELEASE FORM
FOR RELEASE OF HEALTH INFORMATION

_____ _____
Patient's Full Name Date of Birth (Month/Day/Year)

_____ _____
Street Address City, State, Zip Code

I, _____, give my permission for

_____ to share the information listed below with:

RVA Allergy, LLC
7229 Forest Avenue, Suite 104B
Richmond, Virginia 23226.

FAX: (833) 979-0929
Phone: (804) 285-5000

I authorize release of the following information to RVA Allergy, including for continuation of care:

☐ My health record, including notes, skin tests, radiologic results, and lab results

OR

☐ Other (please specify below):

_____

_____

This authorization will expire 12 months from the date of signature unless I indicate a different date here: _____

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign it and I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance upon it.

_____ _____
Signature Date

_____ _____
Printed Name Patient's Name
(if signing as authorized person)