ALLERGY, ASTHMA & SINUS CENTER P.C.

BEHNAM DAGHIGH, M.D. HUONG THAI-KEMPROWSKI, M.D.
KUNAL SHAH, M.D. JILL HAM, N.P.
Diplomate American Board of Allergy & Immunology

19465 Deerfield Avenue, Suite 101♦ Leesburg, VA 20176 ♦ 703-726-9720 ♦ Fax 703-726-9721
205 E. Hirst Road, Suite 202 ♦ Purcellville, VA 20132 ♦ 540-338-1215 ♦ Fax 703-726-9721
46169 West Lake Drive, Suite 140 ♦ Sterling, VA 20165 ♦ 703-444-8592 ♦ Fax 703-726-9721

REQUEST OF MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____ Telephone # _____

I authorize and direct:

Name: _____

Address: _____

City, State, Zip: _____

Telephone # _____ Fax #_____

To release/send the records listed below to Allergy, Asthma & Sinus Center:

_____ Office Visits
_____ Skin Test Results
_____ Allergy Serum Recipe
_____ Allergy Shot Records
_____ Radiology/X-Ray Records
_____ Laboratory Records
_____ PFT Results
_____ Other: _____

_____ _____
Signature of patient or patient's authorized representative Date

_____
Printed name of patient's authorized representative

I understand that after the disclosure of my records, it may no longer be protected by Federal Privacy laws. This release does not authorize redisclosure of medical information beyond the limits of this consent. AASC is prohibited from using the information for other than the stated purpose, and from disclosing it to any other party without further authorization from me, the patient. I understand that this authorization will automatically expire one year from the date of my signature, and that I may revoke this authorization by sending a written notice to AASC. I agree that any release made prior to revocation and which was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality.