MICHAEL E. RUFF, MD
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: ______________________________

Patient Name: ____

Date of Birth: ______________________________ Phone#: ____________________________

Persons/organization(s) **providing** the records:
(Complete address/phone #/fax #)

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Persons/organization(s) **receiving** the records:
(Complete address/phone #/fax #)

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Covering all the periods of care from: _______________________to_________________________

1. Information to be released:

   _________________________ **ONLY RECORDS REQUESTED BY MY DOCTOR**

   ______________________ Copy of complete medical records
   ______________________ Excluding information related to HIV testing and/or results.
   ______________________ History and Physical
   ______________________ Skin Testing results/RAST results
   ______________________ Pulmonary Function Studies
   ______________________ X-Ray reports
   ______________________ Exact composition of current allergenic extract

2. Purpose of Disclosure: ___to send to insurance company ___ to send to new family/general physician __Transfer of care to a new allergist.

3. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

4. Specification of the date, event of condition upon which this consent expires:

   ____

5. The facility, its employees, officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

PLEASE NOTE: A $25 FEE WILL BE ASSESSED FOR COPIES REQUESTED FOR PERSONAL MATTERS
(I.e. personal copies, life insurance policy and attorney requests)

Signed: ____ _______________________ _______________
Patient or Representative Relationship to patient Date