**SHER ALLERGY SPECIALISTS**
**11200 SEMINOLE BLVD., SUITE 310**
**LARGO, FLORIDA 33778**
**Phone: (727)397-8557**
**Fax: (727)397-4459**

# MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize **Sher Allergy Specialists** to release my medical records or copies of such records and request that they be sent to the facility listed below. I consent to the release of protected health information which may be necessary to carry out treatment or health care operations and for other purposes that are permitted or required by law.

**To**:_____

Address:_____

City:_____ State: _____Zip: _____

Please indicate the purpose or reason for this request:

_____ Consulting a new physician in a different specialty.

_____ Moving out of the area.

_____ Transferring medical care to another allergist.

_____ Copy for my personal record.

_____ Other:_____

_____ _____
**(Patient's Name)** **(Patient's Date of Birth)**

I understand that I have the right to revoke this authorization, in writing, at any time, except to the extent that **Sher Allergy Specialists** has taken action in reliance on it. A revocation is effective upon receipt of a written request to revoke authorization.

**Signed by**:_____ _____
(Signature of Patient or Legal Guardian) (Relationship to Patient)

_____ _____
(Print Name of Patient or Legal Guardian) (Today's Date)

This authorization will expire one year from date of authorization or:_____.
{Expiration Date or Defined Event}.