AHWATUKEE FOOTHILLS ALLERGY, ASTHMA & IMMUNOLOGY CLINIC
Allan M. Wachter, M.D., F.A.C.A.A.I., F.C.C.P.
16611 S. 40th Street, Suite 170, Phoenix, AZ 85048
Office: 480 785-8000 Fax: 480 705-8129

MEDICAL RECORDS RELEASE FORM

PATIENT NAME: _____ DOB: _____

I hereby authorize:

Physician's name: Dr. Allan Wachter
Address: Ahwatukee Foothills Allergy
16611 S. 40th Street Suite 170
Phoenix, AZ. 85048

Phone: _____ Fax: _____

To disclose any and all health information, including copies of medical records for the purpose of continuing medical care to the following:

Physician's name: _____

Address: _____

_____

Phone: _____ Fax: _____

_____ ALL RECORDS

_____ LABS/PATHOLOGY

_____ X-RAY/CT/MRI OF THE _____

_____ OTHER (DESCRIBE) _____

_____

Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfill your request. This practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a non-provider under promise of confidentiality concerning their identity, or could place in danger your life or the lives of others.

Signature: _____ Date: _____

Relationship to patient: _____