Allergy & Asthma Specialists, Ltd.

Welcome to our practice!

We are looking forward to meeting you and assisting with your medical care. In an effort to ensure an optimal appointment experience, please arrive 30 minutes prior to your appointment time.

Please begin by completing your registration forms online at www.allergydocs.net. Print, complete all necessary sections, and bring them to your appointment along with:

- picture ID
- insurance cards
- list of all current medications
- notes from referring physician
- pertinent medical records
- referral/authorization (if required)

Your appointment will need to be rescheduled in the event that the above documentation is not presented at the time of check-in.

In the event that **allergy testing** is performed, please refer to the guidelines below:
MEDICARE EXCLUDED
Please wear two piece clothing with an undershirt if possible.

Do not apply any moisturizers to your skin on the day of your appointment.

Abstain from antihistamines 5-7 days prior to your appointment. These include but are not limited to:

- Benadryl (diphenhydramine)
- Zyrtec (cetirizine)
- Xyzal (levocetirizine)
- Claritin (loratadine)
- Clarinex (desloratadine)
- Allegra (fexofenadine)
- Atarax (hydroxyzine)
- Doxepin/Elavil
- Pepcid (famotidine)
- Tagamet (cimetidine)
- Chlorpheniramine/Chlor-Trimeton
- Pataday/Pazeo
- Patanol
- Patanase
- Astepro (astelin)
- Allergy eye drops
- All medications containing “PM”

You may continue ALL other medications including any asthma inhaler(s). If you have questions regarding stopping any medication, please call our office and speak with a member of our nursing staff.

In consideration of our asthmatic patient population, we request that you refrain from using scented lotions, perfumes, and colognes while visiting our office.

If you are unable to keep your appointment, please notify our office 24 hours in advance. Patients will be charged a $75.00 “no show” fee if appointments are not canceled 24 hours prior to their scheduled time. Payment is due at the time of service.

Thank you for taking the time to prepare for your visit to our office. We look forward to seeing you!

-Allergy and Asthma Staff

PATIENT INFORMATION

Name:	Preferred language: ___English Other _____
Address:	Date of Birth:
City:	Social Security #
State: Zip:	Sex: Male____ Female____
Home Phone#:	Referring Physician:
Work Phone#:	Family Dr:
Cell Phone#:	Emergency Contact:
Email address:	Emergency Phone#:
Marital Status: Single Married Widowed Divorced	Emergency Relationship:
Possibility of Pregnancy: Yes No	Employer:
Race: ___Black/ African American ___White ____Asian	Employer address:
___Pacific Islander ___Native American ___Other	Spouse's Name:
Ethnicity: ___ Hispanic/Latino ____ Non-Hispanic/Latino	Spouse's Employer:

RESPONSIBLE PARTY INFORMATION

Name:	Date of Birth:
Address:	Social Security#:
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	Relationship to Patient

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Member#:	Member#:
Group Number:	Group Number:
Group Name:	Group Name:
Effective Date:	Effective Date:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:

Treatment and Financial Responsibility Statement

A. I hereby apply for treatment by the above physicians and/or their assistants. Such treatment is to include X-Rays, injections, preparation of allergy serum, skin testing and such other office procedures as they deem necessary.

B. I, (patient,guarantor) accept responsibility to pay for all services rendered on my behalf.

In the event of default on any payments due ALLERY & ASTHMA SPECIALISTS, LTD, I agree to pay all collection agency fees of 33.3% and/or 33.3% of attorney fees.

C. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to ALLERGY & ASTHMA SPECIALISTS, LTD.

Signature of Patient/Guarantor: _____ Date: _____ Witness: _____

Notice of Deemed Consent HIV Blood Testing

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of the patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of exposure, you will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision. The testing would be explained and you would be given the opportunity to ask any questions you might have. I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing

Date: _____ Patient/Legal Representative: _____

Witness:: _____

Allergy & Asthma Specialists, LTD

New Patient Questionnaire

Patient's Name:

Date of Birth:

Reason for visit:

Patient's Primary Care Physician:

PCP's Phone Number:

PCP's Address:

Other Physician's Involved in Patient's Care:

Preferred Pharmacy & Street Address:

Preferred Lab: ☐Sentara ☐Labcorp ☐CHKD ☐Quest ☐Bon Secour ☐Other:_____

Medications: **Please provide a list of all current medications (prescription and over the counter medications)**

Medication	Strength	Frequency

Known Drug Allergies: ☐ No known drug allergies

Drug	Reaction	Drug	Reaction

Past Medical History: ☐ No past medical history

☐ Asthma	☐ Stroke	☐ Cancer	☐ **Other/Explain:**
☐ Eczema	☐ Thyroid disease	☐ Anxiety	_____
☐ COPD	☐ Arthritis	☐ Depression	_____
☐ Allergic rhinitis	☐ Diabetes	☐ Infections, recurring	_____
☐ Hives	☐ Reflux (GERD)	☐ Latex allergy	_____
☐ High blood pressure	☐ Irritable bowel	☐ Bee/stinging insect allergy	_____
☐ High cholesterol	☐ Celiac disease	☐ Food allergy	_____
☐ Heart disease		Foods:_____	

Last Flu Vaccine:_____ **Last Pneumonia Vaccine:**_____

Surgical History: ☐ No surgical history

New Patient Questionnaire

Social History: Please check all that apply

Work History	☐Full time ☐Part time ☐Retired ☐Not currently working ☐Works from home **Occupation**:
Student	☐Full time ☐Part time ☐N/A **Name of school/daycare**:
Work/School Exposure	☐Dust ☐Air contaminants ☐Chemicals ☐Second hand smoke ☐Symptoms get better at home, worse at work/school
Sports/Hobbies	
Smoking History	☐Never smoked ☐Previous smoker: **Start Age**:_____ **Stop Age**:_____ **Pack(s) per day:**_____ ☐Current smoker: **Start Age**:_____ **Pack(s) per day:**_____
Alcohol Use	☐Never ☐Rarely ☐Socially ☐Daily

Family History:

☐**Patient Adopted**

	Total Number of:	**Please indicate number of siblings/children impacted by the following:**
Father		☐Deceased ☐ Environmental Allergies ☐Asthma ☐Eczema ☐Drug Allergy ☐Food Allergy ☐Insect Allergy ☐Latex Allergy ☐Hives ☐Angioedema ☐Cancer
Mother		☐Deceased ☐ Environmental Allergies ☐Asthma ☐Eczema ☐Drug Allergy ☐Food Allergy ☐Insect Allergy ☐Latex Allergy ☐Hives ☐Angioedema ☐Cancer
Brother(s)	____	__Deceased __Environmental Allergies __Asthma __Eczema __Drug Allergy __Food Allergy __Insect Allergy __Latex Allergy __Hives __Angioedema __Cancer
Sister(s)	____	__Deceased __Environmental Allergies __Asthma __Eczema __Drug Allergy __Food Allergy __Insect Allergy __Latex Allergy __Hives __Angioedema __Cancer
Child(ren)	____	__Deceased __Environmental Allergies __Asthma __Eczema __Drug Allergy __Food Allergy __Insect Allergy __Latex Allergy __Hives __Angioedema __Cancer
Additional immediate family history:		

Environmental History: Please check all that apply

Home	☐House ☐Condo ☐Townhome ☐Apartment ☐Mobile home ☐Dorm ☐Farm
	Year residence was built: Year patient moved into home:
Foundation	☐Slab ☐Crawl space* ☐Basement *Is crawl space sealed? ☐Yes ☐No
Heating	☐Central ☐Baseboard ☐Radiator ☐Wood stove ☐Space heater
Cooling	☐Central ☐Window Units ☐Open windows
Air Quality	Air filters are changed/cleaned every: ☐Month ☐3 months ☐6 months ☐Year
	The home has a(n) ☐Humidifier ☐Dehumidifier ☐HEPA filter ☐Air purifier ☐None
Home Smoke Exposure	☐No exposure to smoke ☐Exposure to second hand smoke ☐Patient smokes
Animal Exposure (Indicate # of animals)	☐None __Dog(s) __Cat(s) __Bird(s) __Rabbit(s) __Horse(s) __Goat(s) __Mice/Rat(s) __Guinea pig(s) __Hamster(s)
Pests Issues	☐None ☐Cockroaches ☐Mice/Rodents ☐Extermination is performed regularly
Mold Issues	☐None ☐Current ☐Previous history
Indoor Plants	☐None ☐ A few ☐A lot
Linens	Washed: ☐Every few days ☐Weekly ☐Every 2 weeks ☐Monthly ☐Infrequently
	Water Temperature: ☐Hot ☐Cold ☐Warm
Pillows	☐Feather ☐Synthetic ☐Dust mite covers
Comforter/Mattress	☐Feather ☐Synthetic ☐Dust mite covers
Flooring	☐Carpet ☐Wood ☐Tile
Overall Cleanliness	☐Clean ☐Dusty ☐Neat ☐Cluttered

New Patient Questionnaire

Review of Systems: Please mark current AND/OR recurring symptoms

Constitutional	☐Fever ☐Chills ☐Fatigue ☐Decrease appetite ☐Night Sweats
Eyes	☐Itchy ☐Redness ☐Watery ☐Redness of eyelid ☐Discharge ☐Dry ☐Worsening vision ☐Swelling of eyelid ☐Gritty ☐Currently wearing contacts ☐Currently wearing glasses
Ears	☐Itchy ☐Full ☐Pressure ☐Popping ☐Earache ☐Ringing ☐Vertigo ☐Hearing loss ☐Drainage
Nose	☐Itching ☐Discharge ☐Sneezing ☐Stuffy ☐Nose bleeds ☐Loss of smell ☐Snoring ☐Mouth breathing
Throat	☐Itchy ☐Postnasal drip ☐Constantly clearing throat ☐Sore throat ☐Hoarseness ☐Difficulty swallowing ☐Mouth sores ☐Mouth dryness
Head/Neck	☐Headache ☐Sinus pain/pressure ☐Headaches during certain seasons ☐Sinus infections ☐Swollen neck glands
Respiratory	☐Difficulty breathing ☐Wheezing ☐Chest tightness ☐Cough ☐Sleep apnea ☐Breathing interrupts sleep ☐Wheezing with exercise
Cardiovascular	☐Chest pain ☐Palpitations ☐Heart murmur ☐Dizziness
Gastrointestinal	☐Heart burn ☐Abdominal discomfort ☐Nausea ☐Vomiting ☐Bloating ☐Diarrhea ☐Constipation
Genitourinary	☐Decreased urine output ☐Feeling dehydrated ☐Urinary incontinence ☐Frequent awakenings to urinate ☐Pain during urination
Psychiatric	☐Anxiety ☐Depression
Neurological	☐Fainting ☐Tingling ☐Numbness ☐Paralysis ☐Limb weakness ☐Confusion ☐Decreased consciousness ☐Memory loss ☐Abnormality of walk ☐Difficulty with balance
Musculoskeletal	☐Muscle aches ☐Joint pain ☐Limb swelling
Endocrine	☐Increased thirst ☐Increased urination ☐Heat intolerance ☐Cold intolerance ☐Alternately too hot/too cold ☐Excessive sweating
Skin	☐Itching ☐Rash ☐Eczema ☐Skin lesions ☐Hives ☐Dermatographic ☐Seborrheic dermatitis ☐ Angioedema ☐Dry ☐Contact dermatitis
Hematology	☐Bruise easily ☐Bleed easily ☐Anemic

Additional pertinent information for today's visit: _____

_____

_____

_____

_____

Name of Person Completing Form: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

Please bring a copy of all pertinent labs and medical records to your appointment.

Allergy& Asthma SPECIALISTS LTD

www.allergydocs.net

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Gregory G. Pendell, M.D.
Lisa Deafenbaugh, PA-C
June Raehl, FNP-BC
Kim Pham, NP-C

Herman Laibstain M.D., Ret.
Burton A. Moss M.D., Ret.
John A. Carlston M.D., Ret.
Harvey D. Davis M.D., Ret.
Kenneth R. King M.D., Ret.

HIPAA

ACKNOWLEDGEMENT

I,_____(patient), acknowledge that I have received a copy of Allergy & Asthma Specialist's Notice Regarding Privacy of Personal Health Information.

Date:_____ _____

(Patient or Responsible Party's Signature)

1704 Sir William Osler Drive
Virginia Beach, VA 23454
(757) 481-4383
Fax (757) 481-4611

155 Kingsley Lane, Ste. 210
Norfolk, VA 23505
(757) 583-4382
Fax (757) 480-3675

300 Medical Pkwy., Ste. 100
Chesapeake, VA 23320
(757) 547-7702
Fax (757) 548-2725

Allergy and Asthma Specialists, Ltd.

Written Financial Policy

Thank you for choosing Allergy and Asthma Specialists, Ltd. Our primary mission is to deliver the best and most comprehensive care available. An Important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

You can choose from:

- Payment in full
- In-house payment plans
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please note:

We also offer In-house payment plans with multiple options of weekly, bi-weekly and monthly payments, and require a partial payment at the beginning of your treatment.

For patients with insurance, we are happy to work with your carrier to maximize your benefit and bill them for services rendered.[2]

A fee of $75 is charged for patients who miss or cancel appointments with lass than 24-hour notice.

Allergy and Asthma Specialists, Ltd. charges $25 for returned checks.

Copays and co-insurances are due at the time of services are rendered.

If you have any questions, please do not hesitate to ask. We are here to help you get the treatment and care you want and need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print) Date of Birth

[1]Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

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APPOINTMENT CANCELLATION AND/OR NO SHOW POLICY

And PATIENT'S WHO ARE RUNNING LATE FOR THEIR APPOINTMENT

We are always happy to be able to work with you and your health care needs and reserve a time in your provider's schedule just for you. However, in consideration of other patients who wish to be seen as soon as possible, we do request at least 24 hours notice prior to cancellation of your appointment to provide us with an opportunity to schedule those patients. A cancellation or no show fee of $75.00 will apply if our office is not notified at least 24 hours in advance that you will be unable to make your appointment.

As a courtesy, we do call in advance to confirm appointments, however, we consider the patient responsible for remembering the date and time of the appointment.

Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment.

Patients, who are more than 15 minutes late for their appointment, may need to be re-scheduled to another day and time, in consideration of other patients and their scheduled appointment times.

We greatly appreciate your understanding of and cooperation with our office policies, and assisting us with accommodating our patients scheduling needs.

Please sign below that you have read, and acknowledge the above information provided to you. If you would like a copy of any of your paperwork, please ask one of our team to make copies for you.

Patient Name: _____

Patient Signature: _____

Date: _____

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STANDARD AUTHORIZATION OF USE AND RELEASE OF PROTECTED HEALTH INFORMATION

Information to be used or released:

[ ] Medical
[ ] Financial

Persons Authorized to use or release information:

Allergy & Asthma Specialists, Ltd.
1704 Sir William Osler Drive
Virginia Beach, Virginia 23454
(757) 481-4383
Fax: (757) 481-4611

Persons to whom information may be released:

Name: _____ Relationship to Patient: _____ Phone #: _____

Name: _____ Relationship to Patient: _____ Phone #: _____

Expiration date of Authorization:
This authorization is effective through _____ unless revoked or terminated by the patient or the patient's personal representative.
[ ] Indefinite

Right to terminate or revoke Authorization:
You may revoke or terminate this authorization by submitting a written revocation to Allergy & Asthma Specialists, Ltd. attention Privacy Officer.

Potential for re-release:
Information that is disclosed under this authorization may be released again by the person or organization to which it is sent. The privacy of this information may not be protected under federal privacy regulation.

Signature:

Name of Patient(Print): _____

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____

Relationship of Representative to Patient: _____

Allergy & Asthma Specialists, LTD.

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Fax: (757) 480-3675

Medical Record Release

Release Medical Records To / From (Circle One)	**Release Medical Records To / From (Circle One)**
Allergy & Asthma Specialists, LTD 1704 Sir William Osler Drive Virginia Beach, VA 23454 Phone: 757-481-4383 Fax: 757-481-4611	_____ _____ _____ _____

Information Requested

- ○ Complete Medical Record
- ○ Labs
- ○ X-Ray Reports
- ○ CT Report
- ○ PFTs
- ○ Allergy Skin Test/Formula/Shot Record
- ○ Medical Record from Previous Year
- ○ Other: _____

Patient Information

Please Print

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone Number: _____
Legal Guardian (if applicable): _____ Relationship: _____

Terms of Disclosure

By signing this release, I hereby authorize you to release the medical information indicated above. I understand this authorization will remain in effect for two years unless otherwise indicated. I have the right to revoke this authorization in writing at any time by writing to the health care provider listed above, except to the extent that action has already been taken based on this authorization. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. My healthcare and payment of that healthcare will not be conditioned upon receipt of this signed authorization

_____ **Date:** _____
Signature of Patient

_____ **Date:** _____
Signature of Legal Guardian (if applicable)

Allergy & Asthma Specialists, Ltd. Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY [Practice Name] AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights.

Upon written request:

- Ask to see or get an electronic or paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost-based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say "no" but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say "no" if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost-based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, [Practice officer, address, phone number and email address]
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy.
- Not to use or share your information other than what is described in this notice unless you communicate approval in writing. If you initially provide approval and then change your mind, please let us know in writing.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

- In these cases, you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:
  - Marketing purposes

- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information with an outside doctor for a referral. We will also provide your health care providers with copies of various reports to assist them with your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

SUD Treatment Information:
If we receive or maintain information about you from a substance use disorder treatment program covered by 42 CFR Part 2 (a "Part 2 Program"), we may use and disclose that information for treatment, payment, or health care operations if you have provided a general consent allowing the Part 2 Program to do so. If we receive your Part 2 Program record through a specific consent you provide to us or another party, we will use and disclose it only as permitted by that consent.

Part 2 Program records are protected by federal law, and any further disclosure is prohibited unless allowed by 42 CFR Part 2. We will not use or disclose your Part 2 Program record, or testimony about it, in any civil, criminal, administrative, or legislative proceeding against you unless you authorize it or a court orders it after providing you notice.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you whether state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all the information we have about you. The new notice will be available on request, in our office and on our website.

AAS Privacy Officer
SEarhart@allergydocs.net
757-583-4382

Effective date: April 14, 2003 Revision Date: February 2, 2026

Allergy & Asthma Specialists, LTD.

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Medical Record Release

Release Medical Records To / From (Circle One)	**Release Medical Records To / From (Circle One)**
Allergy & Asthma Specialists, LTD 1704 Sir William Osler Drive Virginia Beach, VA 23454 Phone: 757-481-4383 Fax: 757-481-4611	_____ _____ _____ _____

Information Requested

- ○ Complete Medical Record
- ○ Labs
- ○ X-Ray Reports
- ○ CT Report
- ○ PFTs
- ○ Allergy Skin Test/Formula/Shot Record
- ○ Medical Record from Previous Year
- ○ Other:_____
  _____
  _____
  _____

Patient Information

Please Print

Patient Name:_____ Date of Birth:_____
Address:_____ City:_____
State:_____ Zip:_____ Phone Number:_____
Legal Guardian (if applicable):_____ Relationship:_____

Terms of Disclosure

By signing this release, I hereby authorize you to release the medical information indicated above. I understand this authorization will remain in effect for two years unless otherwise indicated. I have the right to revoke this authorization in writing at any time by writing to the health care provider listed above, except to the extent that action has already been taken based on this authorization. Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. My healthcare and payment of that healthcare will not be conditioned upon receipt of this signed authorization.

_____ **Date:** _____
Signature of Patient

_____ **Date:** _____
Signature of Legal Guardian (if applicable)