Kenwood Allergy & Asthma Center, PC.

Dr. Pamela A. Georgeson
30170 23 Mile Road
Chesterfield Township, Michigan 48047
Phone: (586) 949-5900
Fax: (586) 949-5922

Dr. Mark L. Decco
17965 Hall Road
Macomb, Michigan 48044
Phone: (586) 846 - 3073
Fax: (586) 846 - 3074

To: Physician/Practice Office Name: ______________________________

Address: ______________________________ Phone #: ______________

______________________________ Fax #: ______________

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Phone #: ______________

______________________________ MRN: ______________

Patient Parent or Legal Guardian (If under 18 years of age): ______________________________

Request for Medical Records – Patient Authorization

I, ______________________________, hereby authorize Kenwood Allergy and Asthma Center, PC to request information contained in my patient records, including "Protected Health Information" (PHI) contained in my medical records. I understand that I have the right to inspect or copy the PHI that will be used or disclosed pursuant to this Authorization. I understand that Kenwood Allergy and Asthma Center, PC will not condition any aspect of my treatment, payment or enrollment in the health plan or eligibility for benefits on whether or not I sign this authorization. I understand that I am under no obligation to sign this authorization.

In accordance with Act 174, Section 5131, ☐ I do authorize ☐ I do not authorize the release of records regarding HIV Infection, AIDS related Complex (ACR), Acquired Immunodeficiency Syndrome (AIDS), and/or serious communicable diseases.

In accordance with Title 42 of the Code of Federal Regulations ☐ I do authorize ☐ I do not authorize the release of records regarding drug/alcohol abuse.

PHI which may be disclosed but not restricted to:

Office Notes	Allergy Testing	Immunotherapy Records	Lab Work
Discharge Notes	Dictated Reports	Radiology/X-Rays	Emergency Reports
PFT	Medication List	Complete Copy	Other: ______________

Information to be: ☐ Faxed ASAP ☐Mailed ☐ Picked up ☐ Patient in office now

______________________________ **Date:** ______________

Signature of Patient/Parent/Legal Guardian

______________________________ **Date:** ______________

Witness