



The Virginia Center for Allergy & Asthma

Robert A. Sikora, M.D., FAAAAI

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information

Name: _____

Address: _____

Date of Birth: _____

Social Security: _____

Please release my Protected Health Information to:
The Virginia Center for Allergy and Asthma, Inc

2296 Opitz Blvd Suite 401
Woodbridge, Virginia 22191
Telephone: (703) 670-3900
Fax: (703) 670-6675

OR

1708 Fall Hill Ave, Suite 201
Fredericksburg, VA 22401
Telephone: (540) 899-1991
Fax: (540) 899-1988

Please include the FOLLOWING ITEMS:

_____ Admission Notes	_____ Laboratory Test	_____ Allergy Test Sheet
_____ Operative Reports	_____ Medication Record	
_____ X-Ray Reports	_____ Complete Records	
_____ Progress Notes	_____ Allergy Shot Record	
_____ Consultation Notes	_____ Immunotherapy Mix Components	

I hereby request and authorize you to release to The Virginia Center for Allergy and Asthma, a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

Signature of Patient/Patient's Parent-Guardian

Date

Relationship to Patient

Request Release from: _____

This Authorization will expire on _____.