

## Grand Traverse Allergy, P.C.

Robert J. Lazar, MD

James S. McClellan, MD

### Authorization To Request Patient Health Information

I, \_\_\_\_\_, authorize

Drs. Office or Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

to furnish Grand Traverse Allergy, PC with a copy of my Personal Health Information.

\_\_\_\_\_ Entire Chart    \_\_\_\_\_ Allergy Testing    \_\_\_\_\_ Labs/X-rays

\_\_\_\_\_ Other (Please explain) \_\_\_\_\_

I release the above stated Office/Facility from any legal responsibility that may arise from this authorization.

Print Patient Name: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

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Fax: (231)995-3658