www.NYAllergy.com
Phone 212.686.6321 Fax 212.686.6329

Morris Nejat, M.D.
Erin Banta, M.D.
Payel Gupta, M.D.
Joanne Moreau, M.D.
Robert Lin, M.D.
Sharon Yee, M.D.
Tricia Lee, M.D.

Kristyl Cuenca-Sisko, PA-C
Toni Santiago, PA-C
Sara Lynn Sterling, PA-C
Allison Glaser, PA-C
Martin Ronan, PA-C
Kyle Colquhoun, PA-C
Yelena Solovyeva, PA-C

Patient: ______________________________ ____________________ **Date of Birth**:______________________

Last First

☐ **This will authorize NYASC to release to:**

Doctor___________________________________

Address___________________________________

____

Telephone_______________________________

Fax______________________________________

☐ **This will authorize your doctor:**

Dr. ________________________________to release to New York Allergy & Sinus Centers.

Fax_____________________________

Telephone__________________________

☐ **This will authorize New York Allergy & Sinus Centers to release to PATIENT:**

Pick Up (select location below)
Third Party ___________________
Email _________________________

NOTE: Email is an inherently insecure form of communication. Please be aware that any sensitive information transmitted via email may be intercepted by a third party. If you request records to be sent through email, you are accepting the inherent security risks associated with email.

Medical Information Requested:
Most Recent Clinical Summary
Allergy Testing
Breathing Tests
Final Lab Results
CT Report
Immunotherapy Schedule/Extract Formula
CT Films/CT (fees may apply)
Complete Records (fees may apply 75 cents/page)
Other___________________________

Reason for Release:
To update my Primary Care Doctor/ENT
I have been referred to another doctor
I want/need a second opinion
To update my specialist
Dissatisfaction with care
My insurance changed
I am moving

Confidential Information

If the requested portion of the record contains information pertaining to mental health, drug or alcohol treatment, or contains HIV related information, you must specifically authorize the release of such information by INITIALING the following three:

______I understand that if my record contains information concerning mental health and/or drug and alcohol treatment, such information will be released pursuant to this authorization.

______I understand that if my record contains confidential HIV related information, such information will be released pursuant to this authorization form.

______This consent may be revoked at any time by notifying the above named provider of information. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

______________________________________ ____________________ __________________
Signature of Patient/Legal Guardian (Required) Relationship to patient Date

This form will expire 3 months from signed date