Foothill Allergy and Immunology

Sheila M Bonilla MD, MS, FAAAAI, FACAAI
Diplomate American Board of Allergy and Immunology

622 W Duarte Rd, Ste 108
Arcadia , CA 91007
Office: (626) 445-1853
Fax: (626) 445-8627

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH CARE INFORMATION

Name (Please Print): ______________________________ **Date:** ____/____/_____
Date of Birth: _____/_____/_____ **Phone #:** (______) - ______ - ______ ☐ Cell ☐ Home ☐ Work

I authorize Foothill Allergy, Asthma and Immunology, office of Sheila M Bonilla MD, to ☐ Receive ☐ Release *information from my patient records as described below*:

Agency / Facility / Person: ______________________________
Address: ______________________________
City: ________________ **State:** _____ **Zip:** ___________
Phone #: (______) - ______ - ______ **Fax #:** (______) - ______ - ______ **For Health Care Facility Fax use only*

Specific Items to be Disclosed: ☐ Immunization Records ☐ Lab Reports ☐ Progress Notes
☐ Antigens ☐ Prescription ☐ Lab Results ☐ Allergy Tests ☐ PFT Results ☐ All ☐ Other
Purpose of Disclosure: ______________________________

____

I UNDERSTAND THE FOLLOWING PROVISIONS:

- I have the right to inspect and receive copies of information to be disclosed.
- I am responsible for paying all charges needed, regarding requested copies of information from the office.
- I have the right to revoke this consent at any time.
- Revoking this consent sent shall have no effect on disclosure made before the revocation of consent.
- Any revocation of consent must be submitted in writing to the Medical Records Unit and signed by the person who gave the consent.
- The confidential information disclosed and used pursuant to this Authorization may be subject to redisclosure by the recipient and no longer protected by law**

This authorization expires within 90 calendar days after it has been signed or upon specified date, arrival of documents, or if certain conditions, or events occur.: ______________________________

____

Signature of Patient / Guardian or Consenting Individual: ____________________ **Date:** ___/___/____
If signature is not of patient, please indicate relationship: ____________________
Signature of witness: ______________________________ **Date:** ___/___/____

____