



CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

BRADLEY E. CHIPPS, M.D.
Pulmonary & Allergic Diseases

Board Certification:

Pediatrics
Pediatric Pulmonology
Allergy and Clinical Immunology

Medical Director, Cystic Fibrosis Center
Assoc. Medical Director Sleep Laboratory
Medical Director of Respiratory Therapy
Sutter Community Hospitals

TRAVIS A. MILLER, M.D.
Allergic and Immunologic
Diseases

Board Certification:

Internal Medicine
Pediatrics
Allergy and Clinical Immunology

Evelyn Keaton, A.C.N.P-BC
Acute Care Nurse Practitioner

Hannah Choi, C.P.N.P
Pediatric Nurse Practitioner

Patient Authorization for Release of Protected Health Information

Patient Name: _____
Patient DOB: _____

I, _____, hereby authorize *Capital Allergy and Respiratory Disease Center (CARDC)* and its clerical staff to disclose all my medical records or _____ (date) until _____ (date).

Check the box and initial which type of information is to be disclosed.

- History and Physical _____ Start Date _____ to End date _____
- Progress Notes _____ Start Date _____ to End date _____
- Spirometry/PFT _____ Start Date _____ to End date _____
- X-Ray Results _____ Start Date _____ to End date _____
- Lab Results _____ Start Date _____ to End date _____
- Discharge Summary _____ Start Date _____ to End date _____
- ER Report _____ Start Date _____ to End date _____
- Skin Tests _____ Start Date _____ to End date _____
- Antigen Formula _____ Start Date _____ to End date _____
- Other _____ Start Date _____ to End date _____

Specify the records to be disclosed:

Recipient _____
Address _____
City, State, Zip code _____

I understand that I have the ability to revoke this authorization by providing CARDC with a written revocation unless CARDC has already disclosed the records to recipient relying upon this Authorization. A written revocation should be sent to Capital Allergy & Respiratory Disease Center at 5609 J Street Suite C, Sacramento, CA. 95819. I further understand that the disclosure of my medical records to the recipient may be disclosed by the recipient and may no longer be protected by federal or state laws. This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here_____. I further understand that CARDC will not condition its provision of treatment to me upon my execution of this Authorization and that my participation is completely voluntary unless any treatment relating to research or health care services are provided to me for the purpose of creating protected health care information to disclose to a third party. I understand that I have the ability to inspect or copy my medical records that will be disclosed to the recipient above.

Signature: Patient or Personal Representative

Authority for Personal Representative