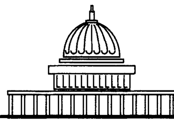

CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

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 to Release Records to Capital Allergy

Patient Name: ____
Patient DOB: ____

I hereby authorize____
(Physician or Hospital)

____
Address

__________________________ ______ _________ ____________________
City State Zip Phone

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

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

Specify the records to be disclosed:

____

Please disclose the following protected health information to:

Capital Allergy and Respiratory Disease Center
1561 Creekside Dr., Suite 130
Folsom, CA 95630
Fax: 916-984-4379

I understand that I have the ability to revoke this authorization 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 at 5609 J Street, Suite C, Sacramento, CA 95819.
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 relation to research or healthcare 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 **Date**

____
Authority for Personal Representative **Date**

MAIN OFFICE: 5609 J STREET, SUITE C • SACRAMENTO, CA 95819 • (916) 453-8696 • FAX (916) 453-8715
FOLSOM OFFICE: 1561 CREEKSIDE DRIVE, SUITE 130 • FOLSOM, CA 95630
ROSEVILLE OFFICE: 1451 SECRET RAVINE PARKWAY, SUITE 150 • ROSEVILLE, CA 95661