



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
5609 J Street, Suite C
Sacramento, CA 95819
Fax: 916-453-8715

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 \_\_\_\_\_