Allergy, Asthma & Sinus Center
Paul S. Judge, M.D.

2550 Niles Road
St. Joseph, MI 49085

951 Pipestone Road
Benton Harbor, MI 49022

PATIENT RECORDS REQUEST FORM

Name of Patient: _____ DOB: _____/_____/_____

Address: _____ Phone:(_____)_____-_____

I authorize: _____ Phone:(_____)_____-_____
Establishment

Address: _____

To release the PHI (Protected Health Information) of the above named patient to:

Establishment: **Allergy, Asthma & Sinus Center** Phone: **(269) 429-1085**

Address**:** **2550 Niles Road, St. Joseph, MI 49085** Fax: **(269) 429-2202**

For the following reason(s): _____

_____

_____

The PHI should contain:

- ❑ The full health record
- ❑ The health record for the following time frame: _____through_____
- ❑ A specific section of the health record: _____

I understand that this request may be revoked at any time in writing to the Allergy, Asthma & Sinus Center.

Signature of Patient: _____Date: _____/_____/_____

Signature of Authorized Personal Representative: _____ Date: _____/_____/_____

Relationship to Patient: _____